S. Hrg. 106–491, Pt. 3

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

S. 2526

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

JULY 26, 2000
WASHINGTON, DC

PART 3

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 106–491, PT. 3

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

S. 2526

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

JULY 26, 2000
WASHINGTON, DC

PART 3

U.S. GOVERNMENT PRINTING OFFICE

66–000 CC WASHINGTON : 2000

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402

COMMITTEE ON INDIAN AFFAIRS

BEN NIGHTHORSE CAMPBELL, Colorado, *Chairman*
DANIEL K. INOUYE, Hawaii, *Vice Chairman*

FRANK MURKOWSKI, Alaska
JOHN McCAIN, Arizona,
SLADE GORTON, Washington
PETE V. DOMENICI, New Mexico
CRAIG THOMAS, Wyoming
ORRIN G. HATCH, Utah
JAMES M. INHOFE, Oklahoma

KENT CONRAD, North Dakota
HARRY REID, Nevada
DANIEL K. AKAKA, Hawaii
PAUL WELLSTONE, Minnesota
BYRON L. DORGAN, North Dakota

PAUL MOOREHEAD *Majority Staff Director/Chief Counsel*
PATRICIA M. ZELL, *Minority Staff Director/Chief Counsel*

CONTENTS

	Page
S. 2526, text of	2
Statements:	
Callahan, John, assistant secretary, Management and Budget, Department of Health and Human Services	343
Campbell, Hon. Ben Nighthorse, U.S. Senator from Colorado, chairman, Committee on Indian Affairs	1
Hill, Virginia, Southern Indian health Council, Inc., on behalf of Denis Turner, executive director	348
McNiel, Melissa, executive officer, Office of Principal Chief, Cherokee Nation	344
Namias, Barbara, president, National Council of Urban Indian Health	346

APPENDIX

Prepared statements:	
Adams, Jacob, president, Artic, Slope Regional Corporation	436
Callahan, John	358
Campbell, Hon. Ben Nighthorse, U.S. Senator from Colorado, chairman, Committee on Indian Affairs	353
Cross, Terry L., executive director, National Indian Child Welfare Association (with attachments)	440
Curtis, Charles, president, NANA Regional Corporation	354
Dorgan, Hon. Byron L., U.S. Senator from North Dakota	354
Hill, Virginia (statement of Ralph Goff and Denis Turner with attachments)	424
McNeil, Melissa	375
Namias, Barbara (with attachments)	385
Pyle, Gregory E., chief, Choctaw Nation of Oklahoma	355
Taylor, Jr., Wayne, chairman, Hopi Tribe (with attachment)	456
Additional material submitted for the record:	
Beaver, R. Perry, principal chief, Muscogee (Creek) Nation (letter)	466
Cheyenne River Tribal Nation (position paper, resolution, letters)	476
Davis, Julia A., Northwest Portland Area Indian Health Board (letter)	470
Dean, S. Bobo, Hobbs, Straus, Dean & Walker (letter)	468
Franklin, Keith E., chairman, Albuquerque Metro Native American Coalition (letter)	473
McNeil, Melissa (questions with responses)	493

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, JULY 26, 2000

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

The committee met, pursuant to other business, at 2:11 p.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell, Inouye, and Dorgan.

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

The CHAIRMAN. I will submit my complete opening statement for the record on S. 2526, since we have a short amount of time.

[Text of S. 2526 follows:]

II

106TH CONGRESS
2D SESSION

S. 2526

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

IN THE SENATE OF THE UNITED STATES

MAY 9, 2000

Mr. CAMPBELL (for himself and for Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

---

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 "Indian Health Care Improvement Act Reauthorization of
6 2000".

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

Sec. 1. Short title.

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

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

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

Sec. 201. Limitations on charges.
Sec. 202. Indian health programs.
Sec. 203. Qualified Indian health program.

Subtitle B—Medicaid

Sec. 211. Payments to Federally-qualified health centers.
Sec. 212. State consultation with Indian health programs.
Sec. 213. Fmap for services provided by Indian health programs.
Sec. 214. Indian Health Service programs.

Subtitle C—State Children's Health Insurance Program

Sec. 221. Enhanced fmap for State children's health insurance program.
Sec. 222. Direct funding of State children's health insurance program.
"Sec. 2111. Direct funding of Indian health programs.

Subtitle D—Authorization of Appropriations

Sec. 231. Authorization of appropriations.

TITLE III—MISCELLANEOUS PROVISIONS

Sec. 301. Repeals.
Sec. 302. Severability provisions.

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

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

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

"(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

1 "(b) TABLE OF CONTENTS.—The table of contents

2 for this Act is as follows:

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

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"Sec. 101. Purpose.
"Sec. 102. General requirements.
"Sec. 103. Health professions recruitment program for Indians.
"Sec. 104. Health professions preparatory scholarship program for Indians.
"Sec. 105. Indian health professions scholarships.
"Sec. 106. American Indians into psychology program.
"Sec. 107. Indian Health Service extern programs.
"Sec. 108. Continuing education allowances.
"Sec. 109. Community health representative program.
"Sec. 110. Indian Health Service loan repayment program.
"Sec. 111. Scholarship and loan repayment recovery fund.
"Sec. 112. Recruitment activities.
"Sec. 113. Tribal recruitment and retention program.
"Sec. 114. Advanced training and research.
"Sec. 115. Nursing programs; Quentin N. Burdick American Indians into Nursing Program.
"Sec. 116. Tribal culture and history.
"Sec. 117. INMED program.
"Sec. 118. Health training programs of community colleges.
"Sec. 119. Retention bonus.
"Sec. 120. Nursing residency program.
"Sec. 121. Community health aide program for Alaska.
"Sec. 122. Tribal health program administration.
"Sec. 123. Health professional chronic shortage demonstration project.
"Sec. 124. Scholarships.
"Sec. 125. National Health Service Corps.
"Sec. 126. Substance abuse counselor education demonstration project.
"Sec. 127. Mental health training and community education.
"Sec. 128. Authorization of appropriations.

"TITLE II—HEALTH SERVICES

"Sec. 201. Indian Health Care Improvement Fund.
"Sec. 202. Catastrophic Health Emergency Fund.
"Sec. 203. Health promotion and disease prevention services.
"Sec. 204. Diabetes prevention, treatment, and control.
"Sec. 205. Shared services.
"Sec. 206. Health services research.
"Sec. 207. Mammography and other cancer screening.
"Sec. 208. Patient travel costs.
"Sec. 209. Epidemiology centers.
"Sec. 210. Comprehensive school health education programs.
"Sec. 211. Indian youth program.

"Sec. 212. Prevention, control, and elimination of communicable and infectious diseases.
"Sec. 213. Authority for provision of other services.
"Sec. 214. Indian women's health care.
"Sec. 215. Environmental and nuclear health hazards.
"Sec. 216. Arizona as a contract health service delivery area.
"Sec. 217. California contract health services demonstration program.
"Sec. 218. California as a contract health service delivery area.
"Sec. 219. Contract health services for the Trenton service area.
"Sec. 220. Programs operated by Indian tribes and tribal organizations.
"Sec. 221. Licensing.
"Sec. 222. Authorization for emergency contract health services.
"Sec. 223. Prompt action on payment of claims.
"Sec. 224. Liability for payment.
"Sec. 225. Authorization of appropriations.

"TITLE III—FACILITIES

"Sec. 301. Consultation, construction and renovation of facilities; reports.
"Sec. 302. Safe water and sanitary waste disposal facilities.
"Sec. 303. Preference to Indians and Indian firms.
"Sec. 304. Soboba sanitation facilities.
"Sec. 305. Expenditure of nonservice funds for renovation.
"Sec. 306. Funding for the construction, expansion, and modernization of small ambulatory care facilities.
"Sec. 307. Indian health care delivery demonstration project.
"Sec. 308. Land transfer.
"Sec. 309. Leases.
"Sec. 310. Loans, loan guarantees and loan repayment.
"Sec. 311. Tribal leasing.
"Sec. 312. Indian Health Service/tribal facilities joint venture program.
"Sec. 313. Location of facilities.
"Sec. 314. Maintenance and improvement of health care facilities.
"Sec. 315. Tribal management of Federally-owned quarters.
"Sec. 316. Applicability of buy American requirement.
"Sec. 317. Other funding for facilities.
"Sec. 318. Authorization of appropriations.

"TITLE IV—ACCESS TO HEALTH SERVICES

"Sec. 401. Treatment of payments under medicare program.
"Sec. 402. Treatment of payments under medicaid program.
"Sec. 403. Report.
"Sec. 404. Grants to and funding agreements with the service, Indian tribes or tribal organizations, and urban Indian organizations.
"Sec. 405. Direct billing and reimbursement of medicare, medicaid, and other third party payors.
"Sec. 406. Reimbursement from certain third parties of costs of health services.
"Sec. 407. Crediting of reimbursements.
"Sec. 408. Purchasing health care coverage.
"Sec. 409. Indian Health Service, Department of Veteran's Affairs, and other Federal agency health facilities and services sharing.
"Sec. 410. Payor of last resort.
"Sec. 411. Right to recover from Federal health care programs.

"Sec. 412. Tuba city demonstration project.
"Sec. 413. Access to Federal insurance.
"Sec. 414. Consultation and rulemaking.
"Sec. 415. Limitations on charges.
"Sec. 416. Limitation on Secretary's waiver authority.
"Sec. 417. Waiver of medicare and medicaid sanctions.
"Sec. 418. Meaning of 'remuneration' for purposes of safe harbor provisions; antitrust immunity.
"Sec. 419. Co-insurance, co-payments, deductibles and premiums.
"Sec. 420. Inclusion of income and resources for purposes of medically needy medicaid eligibility.
"Sec. 421. Estate recovery provisions.
"Sec. 422. Medical child support.
"Sec. 423. Provisions relating to managed care.
"Sec. 424. Navajo Nation medicaid agency.
"Sec. 425. Indian advisory committees.
"Sec. 426. Authorization of appropriations.

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"Sec. 501. Purpose.
"Sec. 502. Contracts with, and grants to, urban Indian organizations.
"Sec. 503. Contracts and grants for the provision of health care and referral services.
"Sec. 504. Contracts and grants for the determination of unmet health care needs.
"Sec. 505. Evaluations; renewals.
"Sec. 506. Other contract and grant requirements.
"Sec. 507. Reports and records.
"Sec. 508. Limitation on contract authority.
"Sec. 509. Facilities.
"Sec. 510. Office of Urban Indian Health.
"Sec. 511. Grants for alcohol and substance abuse related services.
"Sec. 512. Treatment of certain demonstration projects.
"Sec. 513. Urban NIAAA transferred programs.
"Sec. 514. Consultation with urban Indian organizations.
"Sec. 515. Federal Tort Claims Act coverage.
"Sec. 516. Urban youth treatment center demonstration.
"Sec. 517. Use of Federal government facilities and sources of supply.
"Sec. 518. Grants for diabetes prevention, treatment and control.
"Sec. 519. Community health representatives.
"Sec. 520. Regulations.
"Sec. 521. Authorization of appropriations.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"Sec. 601. Establishment of the Indian Health Service as an agency of the Public Health Service.
"Sec. 602. Automated management information system.
"Sec. 603. Authorization of appropriations.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"Sec. 701. Behavioral health prevention and treatment services.
"Sec. 702. Memorandum of agreement with the Department of the Interior.

"Sec. 703. Comprehensive behavioral health prevention and treatment program.
"Sec. 704. Mental health technician program.
"Sec. 705. Licensing requirement for mental health care workers.
"Sec. 706. Indian women treatment programs.
"Sec. 707. Indian youth program.
"Sec. 708. Inpatient and community-based mental health facilities design, construction and staffing assessment. —
"Sec. 709. Training and community education.
"Sec. 710. Behavioral health program.
"Sec. 711. Fetal alcohol disorder funding.
"Sec. 712. Child sexual abuse and prevention treatment programs.
"Sec. 713. Behavioral mental health research.
"Sec. 714. Definitions.
"Sec. 715. Authorization of appropriations.

"TITLE VIII—MISCELLANEOUS

"Sec. 801. Reports.
"Sec. 802. Regulations.
"Sec. 803. Plan of implementation.
"Sec. 804. Availability of funds.
"Sec. 805. Limitation on use of funds appropriated to the Indian Health Service.
"Sec. 806. Eligibility of California Indians.
"Sec. 807. Health services for ineligible persons.
"Sec. 808. Reallocation of base resources.
"Sec. 809. Results of demonstration projects.
"Sec. 810. Provision of services in Montana.
"Sec. 811. Moratorium.
"Sec. 812. Tribal employment.
"Sec. 813. Prime vendor.
"Sec. 814. National Bi-Partisan Commission on Indian Health Care Entitlement.
"Sec. 815. Appropriations; availability.
"Sec. 816. Authorization of appropriations.

1 **"SEC. 2. FINDINGS.**

2 "Congress makes the following findings:

3 "(1) Federal delivery of health services and
4 funding of tribal and urban Indian health programs
5 to maintain and improve the health of the Indians
6 are consonant with and required by the Federal Gov-
7 ernment's historical and unique legal relationship
8 with the American Indian people, as reflected in the
9 Constitution, treaties, Federal laws, and the course

1 of dealings of the United States with Indian Tribes,
2 and the United States' resulting government to gov-
3 ernment and trust responsibility and obligations to
4 the American Indian people.

5 "(2) From the time of European occupation
6 and colonization through the 20th century, the poli-
7 cies and practices of the United States caused or
8 contributed to the severe health conditions of Indi-
9 ans.

10 "(3) Indian Tribes have, through the cession of
11 over 400,000,000 acres of land to the United States
12 in exchange for promises, often reflected in treaties,
13 of health care secured a de facto contract that enti-
14 tles Indians to health care in perpetuity, based on
15 the moral, legal, and historic obligation of the
16 United States.

17 "(4) The population growth of the Indian peo-
18 ple that began in the later part of the 20th century
19 increases the need for Federal health care services.

20 "(5) A major national goal of the United States
21 is to provide the quantity and quality of health serv-
22 ices which will permit the health status of Indians,
23 regardless of where they live, to be raised to the
24 highest possible level, a level that is not less than
25 that of the general population, and to provide for the

1 maximum participation of Indian Tribes, tribal orga-
2 nizations, and urban Indian organizations in the
3 planning, delivery, and management of those serv-
4 ices.

5 "(6) Federal health services to Indians have re-
6 sulted in a reduction in the prevalence and incidence
7 of illnesses among, and unnecessary and premature
8 deaths of, Indians.

9 "(7) Despite such services, the unmet health
10 needs of the American Indian people remain alarm-
11 ingly severe, and even continue to increase, and the
12 health status of the Indians is far below the health
13 status of the general population of the United
14 States.

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

1 **"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.**

2 "Congress hereby declares that it is the policy of the
3 United States, in fulfillment of its special trust respon-
4 sibilities and legal obligations to the American Indian
5 people—

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

9 "(2) to raise the health status of Indians by the
10 year 2010 to at least the levels set forth in the goals
11 contained within the Healthy People 2000, or any
12 successor standards thereto;

13 "(3) in order to raise the health status of In-
14 dian people to at least the levels set forth in the
15 goals contained within the Healthy People 2000, or
16 any successor standards thereto, to permit Indian
17 Tribes and tribal organizations to set their own
18 health care priorities and establish goals that reflect
19 their unmet needs;

20 "(4) to increase the proportion of all degrees in
21 the health professions and allied and associated
22 health professions awarded to Indians so that the
23 proportion of Indian health professionals in each ge-
24 ographic service area is raised to at least the level
25 of that of the general population;

1 "(5) to require meaningful, active consultation
2 with Indian Tribes, Indian organizations, and urban
3 Indian organizations to implement this Act and the
4 national policy of Indian self-determination; and
5 "(6) that funds for health care programs and
6 facilities operated by Tribes and tribal organizations
7 be provided in amounts that are not less than the
8 funds that are provided to programs and facilities
9 operated directly by the Service.

10 **"SEC. 4. DEFINITIONS.**

11 "In this Act:
12 "(1) ACCREDITED AND ACCESSIBLE.—The term
13 'accredited and accessible', with respect to an entity,
14 means a community college or other appropriate en-
15 tity that is on or near a reservation and accredited
16 by a national or regional organization with accredit-
17 ing authority.
18 "(2) AREA OFFICE.—The term 'area office'
19 mean an administrative entity including a program
20 office, within the Indian Health Service through
21 which services and funds are provided to the service
22 units within a defined geographic area.
23 "(3) ASSISTANT SECRETARY.—The term 'As-
24 sistant Secretary' means the Assistant Secretary of
25 the Indian Health as established under section 601.

1 "(4) CONTRACT HEALTH SERVICE.—The term
2 'contract health service' means a health service that
3 is provided at the expense of the Service, Indian
4 Tribe, or tribal organization by a public or private
5 medical provider or hospital, other than a service
6 funded under the Indian Self-Determination and
7 Education Assistance Act or under this Act.
8 "(5) DEPARTMENT.—The term 'Department',
9 unless specifically provided otherwise, means the De-
10 partment of Health and Human Services.
11 "(6) FUND.—The terms 'fund' or 'funding'
12 mean the transfer of monies from the Department
13 to any eligible entity or individual under this Act by
14 any legal means, including funding agreements, con-
15 tracts, memoranda of understanding, Buy Indian
16 Act contracts, or otherwise.
17 "(7) FUNDING AGREEMENT.—The term 'fund-
18 ing agreement' means any agreement to transfer
19 funds for the planning, conduct, and administration
20 of programs, functions, services and activities to
21 Tribes and tribal organizations from the Secretary
22 under the authority of the Indian Self-Determination
23 and Education Assistance Act.
24 "(8) HEALTH PROFESSION.—The term 'health
25 profession' means allopathic medicine, family medi-

1 cine, internal medicine, pediatrics, geriatric medi-
2 cine, obstetrics and gynecology, podiatric medicine,
3 nursing, public health nursing, dentistry, psychiatry,
4 osteopathy, optometry, pharmacy, psychology, public
5 health, social work, marriage and family therapy,
6 chiropractic medicine, environmental health and en-
7 gineering, and allied health professions, or any other
8 health profession.

9 "(9) HEALTH PROMOTION; DISEASE PREVEN-
10 TION.—The terms 'health promotion' and 'disease
11 prevention' shall have the meanings given such
12 terms in paragraphs (1) and (2) of section 203(c).

13 "(10) INDIAN.—The term 'Indian' and 'Indi-
14 ans' shall have meanings given such terms for pur-
15 poses of the Indian Self-Determination and Edu-
16 cation Assistance Act.

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

20 "(12) INDIAN TRIBE.—The term 'Indian tribe'
21 shall have the meaning given such term in section
22 4(e) of the Indian Self Determination and Education
23 Assistance Act.

24 "(13) RESERVATION.—The term 'reservation'
25 means any Federally recognized Indian tribe's res-

1 ervation, Pueblo or colony, including former reserva-
2 tions in Oklahoma, Alaska Native Regions estab-
3 lished pursuant to the Alaska Native Claims Settle-
4 ment Act, and Indian allotments.

5 "(14) SECRETARY.—The term 'Secretary', un-
6 less specifically provided otherwise, means the Sec-
7 retary of Health and Human Services.

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

10 "(16) SERVICE AREA.—The term 'service area'
11 means the geographical area served by each area of-
12 fice.

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

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

17 "(B) a tribe or tribal organization operat-
18 ing health care programs or facilities with funds
19 from the Service under the Indian Self-Deter-
20 mination and Education Assistance Act,
21 through which services are provided, directly or
22 by contract, to the eligible Indian population
23 within a defined geographic area.

24 "(18) TRADITIONAL HEALTH CARE PRAC-
25 TICES.—The term 'traditional health care practices'

1 means the application by Native healing practition-
2 ers of the Native healing sciences (as opposed or in
3 contradistinction to western healing sciences) which
4 embodies the influences or forces of innate tribal dis-
5 covery, history, description, explanation and knowl-
6 edge of the states of wellness and illness and which
7 calls upon these influences or forces, including phys-
8 ical, mental, and spiritual forces in the promotion,
9 restoration, preservation and maintenance of health,
10 well-being, and life's harmony.

11 "(19) TRIBAL ORGANIZATION.—The term 'trib-
12 al organization' shall have the meaning given such
13 term in section 4(l) of the Indian Self Determination
14 and Education Assistance Act.

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

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

1 "(22) URBAN INDIAN.—The term 'urban In-
2 dian' means any individual who resides in an urban
3 center and who—
4 "(A) regardless of whether such individual
5 lives on or near a reservation, is a member of
6 a tribe, band or other organized group of Indi-
7 ans, including those tribes, bands or groups ter-
8 minated since 1940;
9 "(B) is an Eskimo or Aleut or other Alas-
10 kan Native;
11 "(C) is considered by the Secretary of the
12 Interior to be an Indian for any purpose; or
13 "(D) is determined to be an Indian under
14 regulations promulgated by the Secretary.
15 "(23) URBAN INDIAN ORGANIZATION.—The
16 term 'urban Indian organization' means a nonprofit
17 corporate body situated in an urban center, governed
18 by an urban Indian controlled board of directors,
19 and providing for the participation of all interested
20 Indian groups and individuals, and which is capable
21 of legally cooperating with other public and private
22 entities for the purpose of performing the activities
23 described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"SEC. 101. PURPOSE.

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

"SEC. 102. GENERAL REQUIREMENTS.

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

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

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

"(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously con-

1 sult with representatives of Indian tribes, tribal organiza-
2 tions, and urban Indian organizations to prioritize the uti-
3 lization of funds provided under this title within the serv-
4 ice area.

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

10 "(d) LIMITATION.—This section shall not apply with
11 respect to individual recipients of scholarships, loans or
12 other funds provided under this title (as this title existed
13 1 day prior to the date of enactment of this Act) until
14 such time as the individual completes the course of study
15 that is supported through the use of such funds.

16 **"SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM**
17 **FOR INDIANS.**

18 "(a) IN GENERAL.—The Secretary, acting through
19 the Service, shall make funds available through the area
20 office to public or nonprofit private health entities, or In-
21 dian tribes or tribal organizations to assist such entities
22 in meeting the costs of—

23 "(1) identifying Indians with a potential for
24 education or training in the health professions and
25 encouraging and assisting them—

1 "(A) to enroll in courses of study in such
2 health professions; or
3 "(B) if they are not qualified to enroll in
4 any such courses of study, to undertake such
5 postsecondary education or training as may be
6 required to qualify them for enrollment;
7 "(2) publicizing existing sources of financial aid
8 available to Indians enrolled in any course of study
9 referred to in paragraph (1) or who are undertaking
10 training necessary to qualify them to enroll in any
11 such course of study; or
12 "(3) establishing other programs which the area
13 office determines will enhance and facilitate the en-
14 rollment of Indians in, and the subsequent pursuit
15 and completion by them of, courses of study referred
16 to in paragraph (1).
17 "(b) ADMINISTRATIVE PROVISIONS.—
18 "(1) APPLICATION.—To be eligible to receive
19 funds under this section an entity described in sub-
20 section (a) shall submit to the Secretary, through
21 the appropriate area office, and have approved, an
22 application in such form, submitted in such manner,
23 and containing such information as the Secretary
24 shall by regulation prescribe.

1 "(2) PREFERENCE.—In awarding funds under
2 this section, the area office shall give a preference
3 to applications submitted by Indian tribes, tribal or-
4 ganizations, or urban Indian organizations.
5 "(3) AMOUNT.—The amount of funds to be
6 provided to an eligible entity under this section shall
7 be determined by the area office. Payments under
8 this section may be made in advance or by way of
9 reimbursement, and at such intervals and on such
10 conditions as provided for in regulations promul-
11 gated pursuant to this Act.
12 "(4) TERMS.—A funding commitment under
13 this section shall, to the extent not otherwise prohib-
14 ited by law, be for a term of 3 years, as provided
15 for in regulations promulgated pursuant to this Act.
16 "(c) DEFINITION.—For purposes of this section and
17 sections 104 and 105, the terms 'Indian' and 'Indians'
18 shall, in addition to the definition provided for in section
19 4, mean any individual who—
20 "(1) irrespective of whether such individual
21 lives on or near a reservation, is a member of a
22 tribe, band, or other organized group of Indians, in-
23 cluding those Tribes, bands, or groups terminated
24 since 1940;

1 "(2) is an Eskimo or Aleut or other Alaska Na-
2 tive;
3 "(3) is considered by the Secretary of the Inte-
4 rior to be an Indian for any purpose; or
5 "(4) is determined to be an Indian under regu-
6 lations promulgated by the Secretary.

7 **"SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOL-**
8 **ARSHIP PROGRAM FOR INDIANS.**

9 "(a) IN GENERAL.—The Secretary, acting through
10 the Service, shall provide scholarships through the area
11 offices to Indians who—
12 "(1) have successfully completed their high
13 school education or high school equivalency; and
14 "(2) have demonstrated the capability to suc-
15 cessfully complete courses of study in the health pro-
16 fessions.
17 "(b) PURPOSE.—Scholarships provided under this
18 section shall be for the following purposes:
19 "(1) Compensatory preprofessional education of
20 any recipient. Such scholarship shall not exceed 2
21 years on a full-time basis (or the part-time equiva-
22 lent thereof, as determined by the area office pursu-
23 ant to regulations promulgated under this Act).
24 "(2) Pregraduate education of any recipient
25 leading to a baccalaureate degree in an approved

1 course of study preparatory to a field of study in
2 a health profession, such scholarship not to exceed
3 4 years (or the part-time equivalent thereof, as de-
4 termined by the area office pursuant to regulations
5 promulgated under this Act) except that an exten-
6 sion of up to 2 years may be approved by the Sec-
7 retary.

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

12 "(d) LIMITATIONS.—Scholarship assistance to an eli-
13 gible applicant under this section shall not be denied solely
14 on the basis of—

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

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

20 **"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.**

21 "(a) SCHOLARSHIPS.—

22 "(1) IN GENERAL.—In order to meet the needs
23 of Indians, Indian tribes, tribal organizations, and
24 urban Indian organizations for health professionals,
25 the Secretary, acting through the Service and in ac-

1 cordance with this section, shall provide scholarships
2 through the area offices to Indians who are enrolled
3 full or part time in accredited schools and pursuing
4 courses of study in the health professions. Such
5 scholarships shall be designated Indian Health
6 Scholarships and shall, except as provided in sub-
7 section (b), be made in accordance with section
8 338A of the Public Health Service Act (42 U.S.C.
9 254l).

10 "(2) NO DELEGATION.—The Director of the
11 Service shall administer this section and shall not
12 delegate any administrative functions under a fund-
13 ing agreement pursuant to the Indian Self-Deter-
14 mination and Education Assistance Act.

15 "(b) ELIGIBILITY.—

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

20 "(2) SERVICE OBLIGATION.—

21 "(A) PUBLIC HEALTH SERVICE ACT.—The
22 active duty service obligation under a written
23 contract with the Secretary under section 338A
24 of the Public Health Service Act (42 U.S.C.
25 254l) that an Indian has entered into under

1 that section shall, if that individual is a recipi-
2 ent of an Indian Health Scholarship, be met in
3 full-time practice on an equivalent year for year
4 obligation, by service—
5 "(i) in the Indian Health Service;
6 "(ii) in a program conducted under a
7 funding agreement entered into under the
8 Indian Self-Determination and Education
9 Assistance Act;
10 "(iii) in a program assisted under title
11 V; or
12 "(iv) in the private practice of the ap-
13 plicable profession if, as determined by the
14 Secretary, in accordance with guidelines
15 promulgated by the Secretary, such prac-
16 tice is situated in a physician or other
17 health professional shortage area and ad-
18 dresses the health care needs of a substan-
19 tial number of Indians.
20 "(B) DEFERRING ACTIVE SERVICE.—At
21 the request of any Indian who has entered into
22 a contract referred to in subparagraph (A) and
23 who receives a degree in medicine (including os-
24 teopathic or allopathic medicine), dentistry, op-
25 tometry, podiatry, or pharmacy, the Secretary

1 shall defer the active duty service obligation of
2 that individual under that contract, in order
3 that such individual may complete any intern-
4 ship, residency, or other advanced clinical train-
5 ing that is required for the practice of that
6 health profession, for an appropriate period (in
7 years, as determined by the Secretary), subject
8 to the following conditions:
9 "(i) No period of internship, resi-
10 dency, or other advanced clinical training
11 shall be counted as satisfying any period of
12 obligated service that is required under
13 this section.
14 "(ii) The active duty service obligation
15 of that individual shall commence not later
16 than 90 days after the completion of that
17 advanced clinical training (or by a date
18 specified by the Secretary).
19 "(iii) The active duty service obliga-
20 tion will be served in the health profession
21 of that individual, in a manner consistent
22 with clauses (i) through (iv) of subpara-
23 graph (A).
24 "(C) NEW SCHOLARSHIP RECIPIENTS.—A
25 recipient of an Indian Health Scholarship that

1 is awarded after December 31, 2001, shall meet
2 the active duty service obligation under such
3 scholarship by providing service within the serv-
4 ice area from which the scholarship was award-
5 ed. In placing the recipient for active duty the
6 area office shall give priority to the program
7 that funded the recipient, except that in cases
8 of special circumstances, a recipient may be
9 placed in a different service area pursuant to an
10 agreement between the areas or programs in-
11 volved.

12 "(D) PRIORITY IN ASSIGNMENT.—Subject
13 to subparagraph (C), the area office, in making
14 assignments of Indian Health Scholarship re-
15 cipients required to meet the active duty service
16 obligation described in subparagraph (A), shall
17 give priority to assigning individuals to service
18 in those programs specified in subparagraph
19 (A) that have a need for health professionals to
20 provide health care services as a result of indi-
21 viduals having breached contracts entered into
22 under this section.

23 "(3) PART-TIME ENROLLMENT.—In the case of
24 an Indian receiving a scholarship under this section

1 who is enrolled part time in an approved course of
2 study—
3 "(A) such scholarship shall be for a period
4 of years not to exceed the part-time equivalent
5 of 4 years, as determined by the appropriate
6 area office;
7 "(B) the period of obligated service de-
8 scribed in paragraph (2)(A) shall be equal to
9 the greater of—
10 "(i) the part-time equivalent of 1 year
11 for each year for which the individual was
12 provided a scholarship (as determined by
13 the area office); or
14 "(ii) two years; and
15 "(C) the amount of the monthly stipend
16 specified in section 338A(g)(1)(B) of the Public
17 Health Service Act (42 U.S.C. 254l(g)(1)(B))
18 shall be reduced pro rata (as determined by the
19 Secretary) based on the number of hours such
20 student is enrolled.
21 "(4) BREACH OF CONTRACT.—
22 "(A) IN GENERAL.—An Indian who has,
23 on or after the date of the enactment of this
24 paragraph, entered into a written contract with

1 the area office pursuant to a scholarship under
2 this section and who—
3 "(i) fails to maintain an acceptable
4 level of academic standing in the edu-
5 cational institution in which he or she is
6 enrolled (such level determined by the edu-
7 cational institution under regulations of
8 the Secretary);
9 "(ii) is dismissed from such edu-
10 cational institution for disciplinary reasons;
11 "(iii) voluntarily terminates the train-
12 ing in such an educational institution for
13 which he or she is provided a scholarship
14 under such contract before the completion
15 of such training; or
16 "(iv) fails to accept payment, or in-
17 structs the educational institution in which
18 he or she is enrolled not to accept pay-
19 ment, in whole or in part, of a scholarship
20 under such contract;
21 in lieu of any service obligation arising under
22 such contract, shall be liable to the United
23 States for the amount which has been paid to
24 him or her, or on his or her behalf, under the
25 contract.

1 "(B) FAILURE TO PERFORM SERVICE OB-
2 LIGATION.—If for any reason not specified in
3 subparagraph (A) an individual breaches his or
4 her written contract by failing either to begin
5 such individual's service obligation under this
6 section or to complete such service obligation,
7 the United States shall be entitled to recover
8 from the individual an amount determined in
9 accordance with the formula specified in sub-
10 section (l) of section 110 in the manner pro-
11 vided for in such subsection.

12 "(C) DEATH.—Upon the death of an indi-
13 vidual who receives an Indian Health Scholar-
14 ship, any obligation of that individual for serv-
15 ice or payment that relates to that scholarship
16 shall be canceled.

17 "(D) WAIVER.—The Secretary shall pro-
18 vide for the partial or total waiver or suspen-
19 sion of any obligation of service or payment of
20 a recipient of an Indian Health Scholarship if
21 the Secretary, in consultation with the appro-
22 priate area office, Indian tribe, tribal organiza-
23 tion, and urban Indian organization, determines
24 that—

1 "(i) it is not possible for the recipient
2 to meet that obligation or make that pay-
3 ment;
4 "(ii) requiring that recipient to meet
5 that obligation or make that payment
6 would result in extreme hardship to the re-
7 cipient; or
8 "(iii) the enforcement of the require-
9 ment to meet the obligation or make the
10 payment would be unconscionable.
11 "(E) HARDSHIP OR GOOD CAUSE.—Not-
12 withstanding any other provision of law, in any
13 case of extreme hardship or for other good
14 cause shown, the Secretary may waive, in whole
15 or in part, the right of the United States to re-
16 cover funds made available under this section.
17 "(F) BANKRUPTCY.—Notwithstanding any
18 other provision of law, with respect to a recipi-
19 ent of an Indian Health Scholarship, no obliga-
20 tion for payment may be released by a dis-
21 charge in bankruptcy under title 11, United
22 States Code, unless that discharge is granted
23 after the expiration of the 5-year period begin-
24 ning on the initial date on which that payment
25 is due, and only if the bankruptcy court finds

1 that the nondischarge of the obligation would
2 be unconscionable.
3 "(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PRO-
4 GRAMS.—
5 "(1) PROVISION OF FUNDS.—
6 "(A) IN GENERAL.—The Secretary shall
7 make funds available, through area offices, to
8 Indian Tribes and tribal organizations for the
9 purpose of assisting such Tribes and tribal or-
10 ganizations in educating Indians to serve as
11 health professionals in Indian communities.
12 "(B) LIMITATION.—The Secretary shall
13 ensure that amounts available for grants under
14 subparagraph (A) for any fiscal year shall not
15 exceed an amount equal to 5 percent of the
16 amount available for each fiscal year for Indian
17 Health Scholarships under this section.
18 "(C) APPLICATION.—An application for
19 funds under subparagraph (A) shall be in such
20 form and contain such agreements, assurances
21 and information as consistent with this section.
22 "(2) REQUIREMENTS.—
23 "(A) IN GENERAL.—An Indian Tribe or
24 tribal organization receiving funds under para-
25 graph (1) shall agree to provide scholarships to

1 Indians in accordance with the requirements of
2 this subsection.
3 "(B) MATCHING REQUIREMENT.—With re-
4 spect to the costs of providing any scholarship
5 pursuant to subparagraph (A)—
6 "(i) 80 percent of the costs of the
7 scholarship shall be paid from the funds
8 provided under paragraph (1) to the In-
9 dian Tribe or tribal organization; and
10 "(ii) 20 percent of such costs shall be
11 paid from any other source of funds.
12 "(3) ELIGIBILITY.—An Indian Tribe or tribal
13 organization shall provide scholarships under this
14 subsection only to Indians who are enrolled or ac-
15 cepted for enrollment in a course of study (approved
16 by the Secretary) in one of the health professions
17 described in this Act.
18 "(4) CONTRACTS.—In providing scholarships
19 under paragraph (1), the Secretary and the Indian
20 Tribe or tribal organization shall enter into a writ-
21 ten contract with each recipient of such scholarship.
22 Such contract shall—
23 "(A) obligate such recipient to provide
24 service in an Indian health program (as defined
25 in section 110(a)(2)(A)) in the same service

1 area where the Indian Tribe or tribal organiza-
2 tion providing the scholarship is located, for—
3 "(i) a number of years equal to the
4 number of years for which the scholarship
5 is provided (or the part-time equivalent
6 thereof, as determined by the Secretary),
7 or for a period of 2 years, whichever period
8 is greater; or
9 "(ii) such greater period of time as
10 the recipient and the Indian Tribe or tribal
11 organization may agree;
12 "(B) provide that the scholarship—
13 "(i) may only be expended for—
14 "(I) tuition expenses, other rea-
15 sonable educational expenses, and rea-
16 sonable living expenses incurred in at-
17 tendance at the educational institu-
18 tion; and
19 "(II) payment to the recipient of
20 a monthly stipend of not more than
21 the amount authorized by section
22 338(g)(1)(B) of the Public Health
23 Service Act (42 U.S.C.
24 254m(g)(1)(B), such amount to be re-
25 duced pro rata (as determined by the

1 Secretary) based on the number of
2 hours such student is enrolled, and
3 may not exceed, for any year of at-
4 tendance which the scholarship is pro-
5 vided, the total amount required for
6 the year for the purposes authorized
7 in this clause; and
8 "(ii) may not exceed, for any year of
9 attendance which the scholarship is pro-
10 vided, the total amount required for the
11 year for the purposes authorized in clause
12 (i);
13 "(C) require the recipient of such scholar-
14 ship to maintain an acceptable level of academic
15 standing as determined by the educational insti-
16 tution in accordance with regulations issued
17 pursuant to this Act; and
18 "(D) require the recipient of such scholar-
19 ship to meet the educational and licensure re-
20 quirements appropriate to the health profession
21 involved.
22 "(5) BREACH OF CONTRACT.—
23 "(A) IN GENERAL.—An individual who has
24 entered into a written contract with the Sec-

1 retary and an Indian Tribe or tribal organiza-
2 tion under this subsection and who—
3 "(i) fails to maintain an acceptable
4 level of academic standing in the education
5 institution in which he or she is enrolled
6 (such level determined by the educational
7 institution under regulations of the Sec-
8 retary);
9 "(ii) is dismissed from such education
10 for disciplinary reasons;
11 "(iii) voluntarily terminates the train-
12 ing in such an educational institution for
13 which he or she has been provided a schol-
14 arship under such contract before the com-
15 pletion of such training; or
16 "(iv) fails to accept payment, or in-
17 structs the educational institution in which
18 he or she is enrolled not to accept pay-
19 ment, in whole or in part, of a scholarship
20 under such contract, in lieu of any service
21 obligation arising under such contract;
22 shall be liable to the United States for the Fed-
23 eral share of the amount which has been paid
24 to him or her, or on his or her behalf, under
25 the contract.

1 "(B) FAILURE TO PERFORM SERVICE OB-
2 LIGATION.—If for any reason not specified in
3 subparagraph (A), an individual breaches his or
4 her written contract by failing to either begin
5 such individual's service obligation required
6 under such contract or to complete such service
7 obligation, the United States shall be entitled to
8 recover from the individual an amount deter-
9 mined in accordance with the formula specified
10 in subsection (l) of section 110 in the manner
11 provided for in such subsection.
12 "(C) INFORMATION.—The Secretary may
13 carry out this subsection on the basis of infor-
14 mation received from Indian Tribes or tribal or-
15 ganizations involved, or on the basis of informa-
16 tion collected through such other means as the
17 Secretary deems appropriate.
18 "(6) REQUIRED AGREEMENTS.—The recipient
19 of a scholarship under paragraph (1) shall agree, in
20 providing health care pursuant to the requirements
21 of this subsection—
22 "(A) not to discriminate against an indi-
23 vidual seeking care on the basis of the ability
24 of the individual to pay for such care or on the
25 basis that payment for such care will be made

1 pursuant to the program established in title
2 XVIII of the Social Security Act or pursuant to
3 the programs established in title XIX of such
4 Act; and
5 "(B) to accept assignment under section
6 1842(b)(3)(B)(ii) of the Social Security Act for
7 all services for which payment may be made
8 under part B of title XVIII of such Act, and to
9 enter into an appropriate agreement with the
10 State agency that administers the State plan
11 for medical assistance under title XIX of such
12 Act to provide service to individuals entitled to
13 medical assistance under the plan.
14 "(7) PAYMENTS.—The Secretary, through the
15 area office, shall make payments under this sub-
16 section to an Indian Tribe or tribal organization for
17 any fiscal year subsequent to the first fiscal year of
18 such payments unless the Secretary or area office
19 determines that, for the immediately preceding fiscal
20 year, the Indian Tribe or tribal organization has not
21 complied with the requirements of this subsection.
22 **"SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
23 **GRAM.**
24 "(a) IN GENERAL.—Notwithstanding section 102,
25 the Secretary shall provide funds to at least 3 colleges and

1 universities for the purpose of developing and maintaining
2 American Indian psychology career recruitment programs
3 as a means of encouraging Indians to enter the mental
4 health field. These programs shall be located at various
5 colleges and universities throughout the country to maxi-
6 mize their availability to Indian students and new pro-
7 grams shall be established in different locations from time
8 to time.

9 "(b) QUENTIN N. BURDICK AMERICAN INDIANS
10 INTO PSYCHOLOGY PROGRAM.—The Secretary shall pro-
11 vide funds under subsection (a) to develop and maintain
12 a program at the University of North Dakota to be known
13 as the 'Quentin N. Burdick American Indians Into Psy-
14 chology Program'. Such program shall, to the maximum
15 extent feasible, coordinate with the Quentin N. Burdick
16 American Indians Into Nursing Program authorized under
17 section 115, the Quentin N. Burdick Indians into Health
18 Program authorized under section 117, and existing uni-
19 versity research and communications networks.

20 "(c) REQUIREMENTS.—

21 "(1) REGULATIONS.—The Secretary shall pro-
22 mulgate regulations pursuant to this Act for the
23 competitive awarding of funds under this section.

1 "(2) PROGRAM.—Applicants for funds under
2 this section shall agree to provide a program which,
3 at a minimum—
4 "(A) provides outreach and recruitment for
5 health professions to Indian communities in-
6 cluding elementary, secondary and accredited
7 and accessible community colleges that will be
8 served by the program;
9 "(B) incorporates a program advisory
10 board comprised of representatives from the
11 Tribes and communities that will be served by
12 the program;
13 "(C) provides summer enrichment pro-
14 grams to expose Indian students to the various
15 fields of psychology through research, clinical,
16 and experimental activities;
17 "(D) provides stipends to undergraduate
18 and graduate students to pursue a career in
19 psychology;
20 "(E) develops affiliation agreements with
21 tribal community colleges, the Service, univer-
22 sity affiliated programs, and other appropriate
23 accredited and accessible entities to enhance the
24 education of Indian students;

1 "(F) utilizes, to the maximum extent fea-
2 sible, existing university tutoring, counseling
3 and student support services; and
4 "(G) employs, to the maximum extent fea-
5 sible, qualified Indians in the program.
6 "(d) ACTIVE DUTY OBLIGATION.—The active duty
7 service obligation prescribed under section 338C of the
8 Public Health Service Act (42 U.S.C. 254m) shall be met
9 by each graduate who receives a stipend described in sub-
10 section (c)(2)(C) that is funded under this section. Such
11 obligation shall be met by service—
12 "(1) in the Indian Health Service;
13 "(2) in a program conducted under a funding
14 agreement contract entered into under the Indian
15 Self-Determination and Education Assistance Act;
16 "(3) in a program assisted under title V; or
17 "(4) in the private practice of psychology if, as
18 determined by the Secretary, in accordance with
19 guidelines promulgated by the Secretary, such prac-
20 tice is situated in a physician or other health profes-
21 sional shortage area and addresses the health care
22 needs of a substantial number of Indians.
23 **"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.**
24 "(a) IN GENERAL.—Any individual who receives a
25 scholarship pursuant to section 105 shall be entitled to

1 employment in the Service, or may be employed by a pro-
2 gram of an Indian tribe, tribal organization, or urban In-
3 dian organization, or other agency of the Department as
4 may be appropriate and available, during any nonacademic
5 period of the year. Periods of employment pursuant to this
6 subsection shall not be counted in determining the fulfill-
7 ment of the service obligation incurred as a condition of
8 the scholarship.

9 "(b) ENROLLEES IN COURSE OF STUDY.—Any indi-
10 vidual who is enrolled in a course of study in the health
11 professions may be employed by the Service or by an In-
12 dian tribe, tribal organization, or urban Indian organiza-
13 tion, during any nonacademic period of the year. Any such
14 employment shall not exceed 120 days during any calendar
15 year.

16 "(c) HIGH SCHOOL PROGRAMS.—Any individual who
17 is in a high school program authorized under section
18 103(a) may be employed by the Service, or by a Indian
19 Tribe, tribal organization, or urban Indian organization,
20 during any nonacademic period of the year. Any such em-
21 ployment shall not exceed 120 days during any calendar
22 year.

23 "(d) ADMINISTRATIVE PROVISIONS.—Any employ-
24 ment pursuant to this section shall be made without re-
25 gard to any competitive personnel system or agency per-

1 sonnel limitation and to a position which will enable the
2 individual so employed to receive practical experience in
3 the health profession in which he or she is engaged in
4 study. Any individual so employed shall receive payment
5 for his or her services comparable to the salary he or she
6 would receive if he or she were employed in the competitive
7 system. Any individual so employed shall not be counted
8 against any employment ceiling affecting the Service or
9 the Department.

10 **"SEC. 108. CONTINUING EDUCATION ALLOWANCES.**

11 "In order to encourage health professionals, including
12 for purposes of this section, community health representa-
13 tives and emergency medical technicians, to join or con-
14 tinue in the Service or in any program of an Indian tribe,
15 tribal organization, or urban Indian organization and to
16 provide their services in the rural and remote areas where
17 a significant portion of the Indian people reside, the Sec-
18 retary, acting through the area offices, may provide allow-
19 ances to health professionals employed in the Service or
20 such a program to enable such professionals to take leave
21 of their duty stations for a period of time each year (as
22 prescribed by regulations of the Secretary) for professional
23 consultation and refresher training courses.

1 **"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PRO-**
2 **GRAM.**

3 "(a) IN GENERAL.—Under the authority of the Act
4 of November 2, 1921 (25 U.S.C. 13) (commonly known
5 as the Snyder Act), the Secretary shall maintain a Com-
6 munity Health Representative Program under which the
7 Service, Indian tribes and tribal organizations—

8 "(1) provide for the training of Indians as com-
9 munity health representatives; and

10 "(2) use such community health representatives
11 in the provision of health care, health promotion,
12 and disease prevention services to Indian commu-
13 nities.

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

16 "(1) provide a high standard of training for
17 community health representatives to ensure that the
18 community health representatives provide quality
19 health care, health promotion, and disease preven-
20 tion services to the Indian communities served by
21 such Program;

22 "(2) in order to provide such training, develop
23 and maintain a curriculum that—

24 "(A) combines education in the theory of
25 health care with supervised practical experience
26 in the provision of health care; and

1 "(B) provides instruction and practical ex-
2 perience in health promotion and disease pre-
3 vention activities, with appropriate consider-
4 ation given to lifestyle factors that have an im-
5 pact on Indian health status, such as alcohol-
6 ism, family dysfunction, and poverty;
7 "(3) maintain a system which identifies the
8 needs of community health representatives for con-
9 tinuing education in health care, health promotion,
10 and disease prevention and maintain programs that
11 meet the needs for such continuing education;
12 "(4) maintain a system that provides close su-
13 pervision of community health representatives;
14 "(5) maintain a system under which the work
15 of community health representatives is reviewed and
16 evaluated; and
17 "(6) promote traditional health care practices
18 of the Indian tribes served consistent with the Serv-
19 ice standards for the provision of health care, health
20 promotion, and disease prevention.

21 **"SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT**
22 **PROGRAM.**

23 "(a) ESTABLISHMENT.—
24 "(1) IN GENERAL.—The Secretary, acting
25 through the Service, shall establish a program to be

1 known as the Indian Health Service Loan Repay-
2 ment Program (referred to in this Act as the 'Loan
3 Repayment Program') in order to assure an ade-
4 quate supply of trained health professionals nec-
5 essary to maintain accreditation of, and provide
6 health care services to Indians through, Indian
7 health programs.
8 "(2) DEFINITIONS.—In this section:
9 "(A) INDIAN HEALTH PROGRAM.—The
10 term 'Indian health program' means any health
11 program or facility funded, in whole or part, by
12 the Service for the benefit of Indians and
13 administered—
14 "(i) directly by the Service;
15 "(ii) by any Indian tribe or tribal or
16 Indian organization pursuant to a funding
17 agreement under—
18 "(I) the Indian Self-Determina-
19 tion and Educational Assistance Act;
20 or
21 "(II) section 23 of the Act of
22 April 30, 1908 (25 U.S.C. 47) (com-
23 monly known as the 'Buy-Indian
24 Act'); or

1 "(iii) by an urban Indian organization
2 pursuant to title V.
3 "(B) STATE.—The term 'State' has the
4 same meaning given such term in section
5 331(i)(4) of the Public Health Service Act.
6 "(b) ELIGIBILITY.—To be eligible to participate in
7 the Loan Repayment Program, an individual must—
8 "(1)(A) be enrolled—
9 "(i) in a course of study or program in an
10 accredited institution, as determined by the
11 Secretary, within any State and be scheduled to
12 complete such course of study in the same year
13 such individual applies to participate in such
14 program; or
15 "(ii) in an approved graduate training pro-
16 gram in a health profession; or
17 "(B) have—
18 "(i) a degree in a health profession; and
19 "(ii) a license to practice a health profes-
20 sion in a State;
21 "(2)(A) be eligible for, or hold, an appointment
22 as a commissioned officer in the Regular or Reserve
23 Corps of the Public Health Service;

1 "(B) be eligible for selection for civilian service
2 in the Regular or Reserve Corps of the Public
3 Health Service;
4 "(C) meet the professional standards for civil
5 service employment in the Indian Health Service; or
6 "(D) be employed in an Indian health program
7 without a service obligation; and
8 "(3) submit to the Secretary an application for
9 a contract described in subsection (f).
10 "(c) FORMS.—
11 "(1) IN GENERAL.—In disseminating applica-
12 tion forms and contract forms to individuals desiring
13 to participate in the Loan Repayment Program, the
14 Secretary shall include with such forms a fair sum-
15 mary of the rights and liabilities of an individual
16 whose application is approved (and whose contract is
17 accepted) by the Secretary, including in the sum-
18 mary a clear explanation of the damages to which
19 the United States is entitled under subsection (l) in
20 the case of the individual's breach of the contract.
21 The Secretary shall provide such individuals with
22 sufficient information regarding the advantages and
23 disadvantages of service as a commissioned officer in
24 the Regular or Reserve Corps of the Public Health
25 Service or a civilian employee of the Indian Health

1 Service to enable the individual to make a decision
2 on an informed basis.
3 "(2) FORMS TO BE UNDERSTANDABLE.—The
4 application form, contract form, and all other infor-
5 mation furnished by the Secretary under this section
6 shall be written in a manner calculated to be under-
7 stood by the average individual applying to partici-
8 pate in the Loan Repayment Program.
9 "(3) AVAILABILITY.—The Secretary shall make
10 such application forms, contract forms, and other in-
11 formation available to individuals desiring to partici-
12 pate in the Loan Repayment Program on a date suf-
13 ficiently early to ensure that such individuals have
14 adequate time to carefully review and evaluate such
15 forms and information.
16 "(d) PRIORITY.—
17 "(1) ANNUAL DETERMINATIONS.—The Sec-
18 retary, acting through the Service and in accordance
19 with subsection (k), shall annually—
20 "(A) identify the positions in each Indian
21 health program for which there is a need or a
22 vacancy; and
23 "(B) rank those positions in order of prior-
24 ity.

1 "(2) PRIORITY IN APPROVAL.—Consistent with
2 the priority determined under paragraph (1), the
3 Secretary, in determining which applications under
4 the Loan Repayment Program to approve (and
5 which contracts to accept), shall give priority to ap-
6 plications made by—
7 "(A) Indians; and
8 "(B) individuals recruited through the ef-
9 forts an Indian tribe, tribal organization, or
10 urban Indian organization.
11 "(e) CONTRACTS.—
12 "(1) IN GENERAL.—An individual becomes a
13 participant in the Loan Repayment Program only
14 upon the Secretary and the individual entering into
15 a written contract described in subsection (f).
16 "(2) NOTICE.—Not later than 21 days after
17 considering an individual for participation in the
18 Loan Repayment Program under paragraph (1), the
19 Secretary shall provide written notice to the individ-
20 ual of—
21 "(A) the Secretary's approving of the indi-
22 vidual's participation in the Loan Repayment
23 Program, including extensions resulting in an
24 aggregate period of obligated service in excess
25 of 4 years; or

1 "(B) the Secretary's disapproving an indi-
2 vidual's participation in such Program.
3 "(f) WRITTEN CONTRACT.—The written contract re-
4 ferred to in this section between the Secretary and an indi-
5 vidual shall contain—
6 "(1) an agreement under which—
7 "(A) subject to paragraph (3), the Sec-
8 retary agrees—
9 "(i) to pay loans on behalf of the indi-
10 vidual in accordance with the provisions of
11 this section; and
12 "(ii) to accept (subject to the avail-
13 ability of appropriated funds for carrying
14 out this section) the individual into the
15 Service or place the individual with a tribe,
16 tribal organization, or urban Indian orga-
17 nization as provided in subparagraph
18 (B)(iii); and
19 "(B) subject to paragraph (3), the individ-
20 ual agrees—
21 "(i) to accept loan payments on behalf
22 of the individual;
23 "(ii) in the case of an individual de-
24 scribed in subsection (b)(1)—

1 "(I) to maintain enrollment in a
2 course of study or training described
3 in subsection (b)(1)(A) until the indi-
4 vidual completes the course of study
5 or training; and
6 "(II) while enrolled in such
7 course of study or training, to main-
8 tain an acceptable level of academic
9 standing (as determined under regula-
10 tions of the Secretary by the edu-
11 cational institution offering such
12 course of study or training);
13 "(iii) to serve for a time period (re-
14 ferred to in this section as the 'period of
15 obligated service') equal to 2 years or such
16 longer period as the individual may agree
17 to serve in the full-time clinical practice of
18 such individual's profession in an Indian
19 health program to which the individual
20 may be assigned by the Secretary;
21 "(2) a provision permitting the Secretary to ex-
22 tend for such longer additional periods, as the indi-
23 vidual may agree to, the period of obligated service
24 agreed to by the individual under paragraph
25 (1)(B)(iii);

1 "(3) a provision that any financial obligation of
2 the United States arising out of a contract entered
3 into under this section and any obligation of the in-
4 dividual which is conditioned thereon is contingent
5 upon funds being appropriated for loan repayments
6 under this section;
7 "(4) a statement of the damages to which the
8 United States is entitled under subsection (l) for the
9 individual's breach of the contract; and
10 "(5) such other statements of the rights and li-
11 abilities of the Secretary and of the individual, not
12 inconsistent with this section.
13 "(g) LOAN REPAYMENTS.—
14 "(1) IN GENERAL.—A loan repayment provided
15 for an individual under a written contract under the
16 Loan Repayment Program shall consist of payment,
17 in accordance with paragraph (2), on behalf of the
18 individual of the principal, interest, and related ex-
19 penses on government and commercial loans received
20 by the individual regarding the undergraduate or
21 graduate education of the individual (or both), which
22 loans were made for—
23 "(A) tuition expenses;

1 "(B) all other reasonable educational ex-
2 penses, including fees, books, and laboratory ex-
3 penses, incurred by the individual; and
4 "(C) reasonable living expenses as deter-
5 mined by the Secretary.
6 "(2) AMOUNT OF PAYMENT.—
7 "(A) IN GENERAL.—For each year of obli-
8 gated service that an individual contracts to
9 serve under subsection (f) the Secretary may
10 pay up to $35,000 (or an amount equal to the
11 amount specified in section 338B(g)(2)(A) of
12 the Public Health Service Act) on behalf of the
13 individual for loans described in paragraph (1).
14 In making a determination of the amount to
15 pay for a year of such service by an individual,
16 the Secretary shall consider the extent to which
17 each such determination—
18 "(i) affects the ability of the Secretary
19 to maximize the number of contracts that
20 can be provided under the Loan Repay-
21 ment Program from the amounts appro-
22 priated for such contracts;
23 "(ii) provides an incentive to serve in
24 Indian health programs with the greatest
25 shortages of health professionals; and

1 "(iii) provides an incentive with re-
2 spect to the health professional involved re-
3 maining in an Indian health program with
4 such a health professional shortage, and
5 continuing to provide primary health serv-
6 ices, after the completion of the period of
7 obligated service under the Loan Repay-
8 ment Program.
9 "(B) TIME FOR PAYMENT.—Any arrange-
10 ment made by the Secretary for the making of
11 loan repayments in accordance with this sub-
12 section shall provide that any repayments for a
13 year of obligated service shall be made not later
14 than the end of the fiscal year in which the in-
15 dividual completes such year of service.
16 "(3) SCHEDULE FOR PAYMENTS.—The Sec-
17 retary may enter into an agreement with the holder
18 of any loan for which payments are made under the
19 Loan Repayment Program to establish a schedule
20 for the making of such payments.
21 "(h) COUNTING OF INDIVIDUALS.—Notwithstanding
22 any other provision of law, individuals who have entered
23 into written contracts with the Secretary under this sec-
24 tion, while undergoing academic training, shall not be

1 counted against any employment ceiling affecting the De-
2 partment.

3 "(i) RECRUITING PROGRAMS.—The Secretary shall
4 conduct recruiting programs for the Loan Repayment Pro-
5 gram and other health professional programs of the Serv-
6 ice at educational institutions training health professionals
7 or specialists identified in subsection (a).

8 "(j) NONAPPLICATION OF CERTAIN PROVISION.—
9 Section 214 of the Public Health Service Act (42 U.S.C.
10 215) shall not apply to individuals during their period of
11 obligated service under the Loan Repayment Program.

12 "(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary,
13 in assigning individuals to serve in Indian health programs
14 pursuant to contracts entered into under this section,
15 shall—

16 "(1) ensure that the staffing needs of Indian
17 health programs administered by an Indian tribe or
18 tribal or health organization receive consideration on
19 an equal basis with programs that are administered
20 directly by the Service; and

21 "(2) give priority to assigning individuals to In-
22 dian health programs that have a need for health
23 professionals to provide health care services as a re-
24 sult of individuals having breached contracts entered
25 into under this section.

1 "(l) BREACH OF CONTRACT.—

2 "(1) IN GENERAL.—An individual who has en-
3 tered into a written contract with the Secretary
4 under this section and who—

5 "(A) is enrolled in the final year of a
6 course of study and who—

7 "(i) fails to maintain an acceptable
8 level of academic standing in the edu-
9 cational institution in which he is enrolled
10 (such level determined by the educational
11 institution under regulations of the Sec-
12 retary);

13 "(ii) voluntarily terminates such en-
14 rollment; or

15 "(iii) is dismissed from such edu-
16 cational institution before completion of
17 such course of study; or

18 "(B) is enrolled in a graduate training pro-
19 gram, and who fails to complete such training
20 program, and does not receive a waiver from
21 the Secretary under subsection (b)(1)(B)(ii),

22 shall be liable, in lieu of any service obligation aris-
23 ing under such contract, to the United States for the
24 amount which has been paid on such individual's be-
25 half under the contract.

1 "(2) AMOUNT OF RECOVERY.—If, for any rea-
2 son not specified in paragraph (1), an individual
3 breaches his written contract under this section by
4 failing either to begin, or complete, such individual's
5 period of obligated service in accordance with sub-
6 section (f), the United States shall be entitled to re-
7 cover from such individual an amount to be deter-
8 mined in accordance with the following formula:

9 $$A=3Z(t-s/t)$$

10 in which—

11 "(A) 'A' is the amount the United States
12 is entitled to recover;

13 "(B) 'Z' is the sum of the amounts paid
14 under this section to, or on behalf of, the indi-
15 vidual and the interest on such amounts which
16 would be payable if, at the time the amounts
17 were paid, they were loans bearing interest at
18 the maximum legal prevailing rate, as deter-
19 mined by the Treasurer of the United States;

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

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

1 Amounts not paid within such period shall be sub-
2 ject to collection through deductions in Medicare
3 payments pursuant to section 1892 of the Social Se-
4 curity Act.

5 "(3) DAMAGES.—

6 "(A) TIME FOR PAYMENT.—Any amount
7 of damages which the United States is entitled
8 to recover under this subsection shall be paid to
9 the United States within the 1-year period be-
10 ginning on the date of the breach of contract or
11 such longer period beginning on such date as
12 shall be specified by the Secretary.

13 "(B) DELINQUENCIES.—If damages de-
14 scribed in subparagraph (A) are delinquent for
15 3 months, the Secretary shall, for the purpose
16 of recovering such damages—

17 "(i) utilize collection agencies con-
18 tracted with by the Administrator of the
19 General Services Administration; or

20 "(ii) enter into contracts for the re-
21 covery of such damages with collection
22 agencies selected by the Secretary.

23 "(C) CONTRACTS FOR RECOVERY OF DAM-
24 AGES.—Each contract for recovering damages
25 pursuant to this subsection shall provide that

1 the contractor will, not less than once each 6
2 months, submit to the Secretary a status report
3 on the success of the contractor in collecting
4 such damages. Section 3718 of title 31, United
5 States Code, shall apply to any such contract to
6 the extent not inconsistent with this subsection.
7 "(m) CANCELLATION, WAIVER OR RELEASE.—
8 "(1) CANCELLATION.—Any obligation of an in-
9 dividual under the Loan Repayment Program for
10 service or payment of damages shall be canceled
11 upon the death of the individual.
12 "(2) WAIVER OF SERVICE OBLIGATION.—The
13 Secretary shall by regulation provide for the partial
14 or total waiver or suspension of any obligation of
15 service or payment by an individual under the Loan
16 Repayment Program whenever compliance by the in-
17 dividual is impossible or would involve extreme hard-
18 ship to the individual and if enforcement of such ob-
19 ligation with respect to any individual would be un-
20 conscionable.
21 "(3) WAIVER OF RIGHTS OF UNITED STATES.—
22 The Secretary may waive, in whole or in part, the
23 rights of the United States to recover amounts
24 under this section in any case of extreme hardship

1 or other good cause shown, as determined by the
2 Secretary.
3 "(4) RELEASE.—Any obligation of an individual
4 under the Loan Repayment Program for payment of
5 damages may be released by a discharge in bank-
6 ruptcy under title 11 of the United States Code only
7 if such discharge is granted after the expiration of
8 the 5-year period beginning on the first date that
9 payment of such damages is required, and only if
10 the bankruptcy court finds that nondischarge of the
11 obligation would be unconscionable.
12 "(n) REPORT.—The Secretary shall submit to the
13 President, for inclusion in each report required to be sub-
14 mitted to the Congress under section 801, a report con-
15 cerning the previous fiscal year which sets forth—
16 "(1) the health professional positions main-
17 tained by the Service or by tribal or Indian organi-
18 zations for which recruitment or retention is dif-
19 ficult;
20 "(2) the number of Loan Repayment Program
21 applications filed with respect to each type of health
22 profession;
23 "(3) the number of contracts described in sub-
24 section (f) that are entered into with respect to each
25 health profession;

1 "(4) the amount of loan payments made under
2 this section, in total and by health profession;
3 "(5) the number of scholarship grants that are
4 provided under section 105 with respect to each
5 health profession;
6 "(6) the amount of scholarship grants provided
7 under section 105, in total and by health profession;
8 "(7) the number of providers of health care
9 that will be needed by Indian health programs, by
10 location and profession, during the 3 fiscal years be-
11 ginning after the date the report is filed; and
12 "(8) the measures the Secretary plans to take
13 to fill the health professional positions maintained
14 by the Service or by tribes, tribal organizations, or
15 urban Indian organizations for which recruitment or
16 retention is difficult.

17 **"SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOV-**
18 **ERY FUND.**

19 "(a) ESTABLISHMENT.—Notwithstanding section
20 102, there is established in the Treasury of the United
21 States a fund to be known as the Indian Health Scholar-
22 ship and Loan Repayment Recovery Fund (referred to in
23 this section as the 'LRRF'). The LRRF Fund shall con-
24 sist of—

1 "(1) such amounts as may be collected from in-
2 dividuals under subparagraphs (A) and (B) of sec-
3 tion 105(b)(4) and section 110(l) for breach of con-
4 tract;
5 "(2) such funds as may be appropriated to the
6 LRRF;
7 "(3) such interest earned on amounts in the
8 LRRF; and
9 "(4) such additional amounts as may be col-
10 lected, appropriated, or earned relative to the
11 LRRF.
12 Amounts appropriated to the LRRF shall remain available
13 until expended.
14 "(b) USE OF LRRF.—
15 "(1) IN GENERAL.—Amounts in the LRRF
16 may be expended by the Secretary, subject to section
17 102, acting through the Service, to make payments
18 to the Service or to an Indian tribe or tribal organi-
19 zation administering a health care program pursuant
20 to a funding agreement entered into under the In-
21 dian Self-Determination and Education Assistance
22 Act—
23 "(A) to which a scholarship recipient under
24 section 105 or a loan repayment program par-
25 ticipant under section 110 has been assigned to

1 meet the obligated service requirements pursu-
2 ant to sections; and
3 "(B) that has a need for a health profes-
4 sional to provide health care services as a result
5 of such recipient or participant having breached
6 the contract entered into under section 105 or
7 section 110.
8 "(2) SCHOLARSHIPS AND RECRUITING.—An In-
9 dian tribe or tribal organization receiving payments
10 pursuant to paragraph (1) may expend the payments
11 to provide scholarships or to recruit and employ, di-
12 rectly or by contract, health professionals to provide
13 health care services.
14 "(c) INVESTING OF FUND.—
15 "(1) IN GENERAL.—The Secretary of the
16 Treasury shall invest such amounts of the LRRF as
17 the Secretary determines are not required to meet
18 current withdrawals from the LRRF. Such invest-
19 ments may be made only in interest-bearing obliga-
20 tions of the United States. For such purpose, such
21 obligations may be acquired on original issue at the
22 issue price, or by purchase of outstanding obliga-
23 tions at the market price.

1 "(2) SALE PRICE.—Any obligation acquired by
2 the LRRF may be sold by the Secretary of the
3 Treasury at the market price.

4 **"SEC. 112. RECRUITMENT ACTIVITIES.**

5 "(a) REIMBURSEMENT OF EXPENSES.—The Sec-
6 retary may reimburse health professionals seeking posi-
7 tions in the Service, Indian tribes, tribal organizations, or
8 urban Indian organizations, including unpaid student vol-
9 unteers and individuals considering entering into a con-
10 tract under section 110, and their spouses, for actual and
11 reasonable expenses incurred in traveling to and from
12 their places of residence to an area in which they may
13 be assigned for the purpose of evaluating such area with
14 respect to such assignment.

15 "(b) ASSIGNMENT OF PERSONNEL.—The Secretary,
16 acting through the Service, shall assign one individual in
17 each area office to be responsible on a full-time basis for
18 recruitment activities.

19 **"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PRO-**
20 **GRAM.**

21 "(a) FUNDING OF PROJECTS.—The Secretary, acting
22 through the Service, shall fund innovative projects for a
23 period not to exceed 3 years to enable Indian tribes, tribal
24 organizations, and urban Indian organizations to recruit,
25 place, and retain health professionals to meet the staffing

1 needs of Indian health programs (as defined in section
2 110(a)(2)(A)).
3 "(b) ELIGIBILITY.—Any Indian tribe, tribal organi-
4 zation, or urban Indian organization may submit an appli-
5 cation for funding of a project pursuant to this section.
6 **"SEC. 114. ADVANCED TRAINING AND RESEARCH.**
7 "(a) DEMONSTRATION PROJECT.—The Secretary,
8 acting through the Service, shall establish a demonstration
9 project to enable health professionals who have worked in
10 an Indian health program (as defined in section 110) for
11 a substantial period of time to pursue advanced training
12 or research in areas of study for which the Secretary de-
13 termines a need exists.
14 "(b) SERVICE OBLIGATION.—
15 "(1) IN GENERAL.—An individual who partici-
16 pates in the project under subsection (a), where the
17 educational costs are borne by the Service, shall
18 incur an obligation to serve in an Indian health pro-
19 gram for a period of obligated service equal to at
20 least the period of time during which the individual
21 participates in such project.
22 "(2) FAILURE TO COMPLETE SERVICE.—In the
23 event that an individual fails to complete a period of
24 obligated service under paragraph (1), the individual
25 shall be liable to the United States for the period of

1 service remaining. In such event, with respect to in-
2 dividuals entering the project after the date of the
3 enactment of this Act, the United States shall be en-
4 titled to recover from such individual an amount to
5 be determined in accordance with the formula speci-
6 fied in subsection (l) of section 110 in the manner
7 provided for in such subsection.

8 "(c) OPPORTUNITY TO PARTICIPATE.—Health pro-
9 fessionals from Indian tribes, tribal organizations, and
10 urban Indian organizations under the authority of the In-
11 dian Self-Determination and Education Assistance Act
12 shall be given an equal opportunity to participate in the
13 program under subsection (a).

14 **"SEC. 115. NURSING PROGRAMS; QUENTIN N. BURDICK**
15 **AMERICAN INDIANS INTO NURSING PRO-**
16 **GRAM.**

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

20 "(1) public or private schools of nursing;

21 "(2) tribally controlled community colleges and
22 tribally controlled postsecondary vocational institu-
23 tions (as defined in section 390(2) of the Tribally
24 Controlled Vocational Institutions Support Act of
25 1990 (20 U.S.C. 2397h(2)); and

1 "(3) nurse midwife programs, and advance
2 practice nurse programs, that are provided by any
3 tribal college accredited nursing program, or in the
4 absence of such, any other public or private institu-
5 tion,
6 for the purpose of increasing the number of nurses, nurse
7 midwives, and nurse practitioners who deliver health care
8 services to Indians.
9 "(b) USE OF GRANTS.—Funds provided under sub-
10 section (a) may be used to—
11 "(1) recruit individuals for programs which
12 train individuals to be nurses, nurse midwives, or
13 advanced practice nurses;
14 "(2) provide scholarships to Indian individuals
15 enrolled in such programs that may be used to pay
16 the tuition charged for such program and for other
17 expenses incurred in connection with such program,
18 including books, fees, room and board, and stipends
19 for living expenses;
20 "(3) provide a program that encourages nurses,
21 nurse midwives, and advanced practice nurses to
22 provide, or continue to provide, health care services
23 to Indians;

1 "(4) provide a program that increases the skills
2 of, and provides continuing education to, nurses,
3 nurse midwives, and advanced practice nurses; or
4 "(5) provide any program that is designed to
5 achieve the purpose described in subsection (a).
6 "(c) APPLICATIONS.—Each application for funds
7 under subsection (a) shall include such information as the
8 Secretary may require to establish the connection between
9 the program of the applicant and a health care facility
10 that primarily serves Indians.
11 "(d) PREFERENCES.—In providing funds under sub-
12 section (a), the Secretary shall extend a preference to—
13 "(1) programs that provide a preference to In-
14 dians;
15 "(2) programs that train nurse midwives or ad-
16 vanced practice nurses;
17 "(3) programs that are interdisciplinary; and
18 "(4) programs that are conducted in coopera-
19 tion with a center for gifted and talented Indian stu-
20 dents established under section 5324(a) of the In-
21 dian Education Act of 1988.
22 "(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO
23 NURSING PROGRAM.—The Secretary shall ensure that a
24 portion of the funds authorized under subsection (a) is
25 made available to establish and maintain a program at the

1 University of North Dakota to be known as the 'Quentin
2 N. Burdick American Indians Into Nursing Program'.
3 Such program shall, to the maximum extent feasible, co-
4 ordinate with the Quentin N. Burdick American Indians
5 Into Psychology Program established under section 106(b)
6 and the Quentin N. Burdick Indian Health Programs es-
7 tablished under section 117(b).

8 "(f) SERVICE OBLIGATION.—The active duty service
9 obligation prescribed under section 338C of the Public
10 Health Service Act (42 U.S.C. 254m) shall be met by each
11 individual who receives training or assistance described in
12 paragraph (1) or (2) of subsection (b) that is funded
13 under subsection (a). Such obligation shall be met by
14 service—

15 "(1) in the Indian Health Service;

16 "(2) in a program conducted under a contract
17 entered into under the Indian Self-Determination
18 and Education assistance Act;

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

20 "(4) in the private practice of nursing if, as de-
21 termined by the Secretary, in accordance with guide-
22 lines promulgated by the Secretary, such practice is
23 situated in a physician or other health professional
24 shortage area and addresses the health care needs of
25 a substantial number of Indians.

1 **"SEC. 116. TRIBAL CULTURE AND HISTORY.**

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

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

10 "(1) be provided in consultation with the af-
11 fected tribal governments, tribal organizations, and
12 urban Indian organizations;

13 "(2) be provided through tribally-controlled
14 community colleges (within the meaning of section
15 2(4) of the Tribally Controlled Community College
16 Assistance Act of 1978) and tribally controlled post-
17 secondary vocational institutions (as defined in sec-
18 tion 390(2) of the Tribally Controlled Vocational In-
19 stitutions Support Act of 1990 (20 U.S.C.
20 2397h(2)); and

21 "(3) include instruction in Native American
22 studies.

23 **"SEC. 117. INMED PROGRAM.**

24 "(a) GRANTS.—The Secretary may provide grants to
25 3 colleges and universities for the purpose of maintaining
26 and expanding the Native American health careers recruit-

1 ment program known as the 'Indians into Medicine Pro-
2 gram' (referred to in this section as 'INMED') as a means
3 of encouraging Indians to enter the health professions.
4 "(b) QUENTIN N. BURDICK INDIAN HEALTH PRO-
5 GRAM.—The Secretary shall provide 1 of the grants under
6 subsection (a) to maintain the INMED program at the
7 University of North Dakota, to be known as the 'Quentin
8 N. Burdick Indian Health Program', unless the Secretary
9 makes a determination, based upon program reviews, that
10 the program is not meeting the purposes of this section.
11 Such program shall, to the maximum extent feasible, co-
12 ordinate with the Quentin N. Burdick American Indians
13 Into Psychology Program established under section 106(b)
14 and the Quentin N. Burdick American Indians Into Nurs-
15 ing Program established under section 115.
16 "(c) REQUIREMENTS.—
17 "(1) IN GENERAL.—The Secretary shall develop
18 regulations to govern grants under to this section.
19 "(2) PROGRAM REQUIREMENTS.—Applicants
20 for grants provided under this section shall agree to
21 provide a program that—
22 "(A) provides outreach and recruitment for
23 health professions to Indian communities in-
24 cluding elementary, secondary and community

1 colleges located on Indian reservations which
2 will be served by the program;
3 "(B) incorporates a program advisory
4 board comprised of representatives from the
5 tribes and communities which will be served by
6 the program;
7 "(C) provides summer preparatory pro-
8 grams for Indian students who need enrichment
9 in the subjects of math and science in order to
10 pursue training in the health professions;
11 "(D) provides tutoring, counseling and
12 support to students who are enrolled in a health
13 career program of study at the respective col-
14 lege or university; and
15 "(E) to the maximum extent feasible, em-
16 ploys qualified Indians in the program.
17 **"SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY**
18 **COLLEGES.**
19 "(a) ESTABLISHMENT GRANTS.—
20 "(1) IN GENERAL.—The Secretary, acting
21 through the Service, shall award grants to accredited
22 and accessible community colleges for the purpose of
23 assisting such colleges in the establishment of pro-
24 grams which provide education in a health profes-
25 sion leading to a degree or diploma in a health pro-

1 fession for individuals who desire to practice such
2 profession on an Indian reservation, in the Service,
3 or in a tribal health program.

4 "(2) AMOUNT.—The amount of any grant
5 awarded to a community college under paragraph
6 (1) for the first year in which such a grant is pro-
7 vided to the community college shall not exceed
8 $100,000.

9 "(b) CONTINUATION GRANTS.—

10 "(1) IN GENERAL.—The Secretary, acting
11 through the Service, shall award grants to accredited
12 and accessible community colleges that have estab-
13 lished a program described in subsection (a)(1) for
14 the purpose of maintaining the program and recruit-
15 ing students for the program.

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

18 "(A) is accredited;

19 "(B) has a relationship with a hospital fa-
20 cility, Service facility, or hospital that could
21 provide training of nurses or health profes-
22 sionals;

23 "(C) has entered into an agreement with
24 an accredited college or university medical
25 school, the terms of which—

1 "(i) provide a program that enhances
2 the transition and recruitment of students
3 into advanced baccalaureate or graduate
4 programs which train health professionals;
5 and
6 "(ii) stipulate certifications necessary
7 to approve internship and field placement
8 opportunities at health programs of the
9 Service or at tribal health programs;
10 "(D) has a qualified staff which has the
11 appropriate certifications;
12 "(E) is capable of obtaining State or re-
13 gional accreditation of the program described in
14 subsection (a)(1); and
15 "(F) agrees to provide for Indian pref-
16 erence for applicants for programs under this
17 section.
18 "(c) SERVICE PERSONNEL AND TECHNICAL ASSIST-
19 ANCE.—The Secretary shall encourage community colleges
20 described in subsection (b)(2) to establish and maintain
21 programs described in subsection (a)(1) by—
22 "(1) entering into agreements with such col-
23 leges for the provision of qualified personnel of the
24 Service to teach courses of study in such programs,
25 and

1 "(2) providing technical assistance and support
2 to such colleges.
3 "(d) SPECIFIED COURSES OF STUDY.—Any program
4 receiving assistance under this section that is conducted
5 with respect to a health profession shall also offer courses
6 of study which provide advanced training for any health
7 professional who—
8 "(1) has already received a degree or diploma
9 in such health profession; and
10 "(2) provides clinical services on an Indian res-
11 ervation, at a Service facility, or at a tribal clinic.
12 Such courses of study may be offered in conjunction with
13 the college or university with which the community college
14 has entered into the agreement required under subsection
15 (b)(2)(C).
16 "(e) PRIORITY.—Priority shall be provided under this
17 section to tribally controlled colleges in service areas that
18 meet the requirements of subsection (b).
19 "(f) DEFINITIONS.—In this section:
20 "(1) COMMUNITY COLLEGE.—The term 'com-
21 munity college' means—
22 "(A) a tribally controlled community col-
23 lege; or
24 "(B) a junior or community college.

1 "(2) JUNIOR OR COMMUNITY COLLEGE.—The
2 term 'junior or community college" has the meaning
3 given such term by section 312(e) of the Higher
4 Education Act of 1965 (20 U.S.C. 1058(e)).
5 "(3) TRIBALLY CONTROLLED COLLEGE.—The
6 term 'tribally controlled college' has the meaning
7 given the term 'tribally controlled community college'
8 by section 2(4) of the Tribally Controlled Commu-
9 nity College Assistance Act of 1978.
10 **"SEC. 119. RETENTION BONUS.**
11 "(a) IN GENERAL.—The Secretary may pay a reten-
12 tion bonus to any health professional employed by, or as-
13 signed to, and serving in, the Service, an Indian tribe, a
14 tribal organization, or an urban Indian organization either
15 as a civilian employee or as a commissioned officer in the
16 Regular or Reserve Corps of the Public Health Service
17 who—
18 "(1) is assigned to, and serving in, a position
19 for which recruitment or retention of personnel is
20 difficult;
21 "(2) the Secretary determines is needed by the
22 Service, tribe, tribal organization, or urban organiza-
23 tion;
24 "(3) has—

1 "(A) completed 3 years of employment
2 with the Service; tribe, tribal organization, or
3 urban organization; or
4 "(B) completed any service obligations in-
5 curred as a requirement of—
6 "(i) any Federal scholarship program;
7 or
8 "(ii) any Federal education loan re-
9 payment program; and
10 "(4) enters into an agreement with the Service,
11 Indian tribe, tribal organization, or urban Indian or-
12 ganization for continued employment for a period of
13 not less than 1 year.
14 "(b) RATES.—The Secretary may establish rates for
15 the retention bonus which shall provide for a higher an-
16 nual rate for multiyear agreements than for single year
17 agreements referred to in subsection (a)(4), but in no
18 event shall the annual rate be more than $25,000 per
19 annum.
20 "(c) FAILURE TO COMPLETE TERM OF SERVICE.—
21 Any health professional failing to complete the agreed
22 upon term of service, except where such failure is through
23 no fault of the individual, shall be obligated to refund to
24 the Government the full amount of the retention bonus
25 for the period covered by the agreement, plus interest as

1 determined by the Secretary in accordance with section
2 110(l)(2)(B).
3 "(d) FUNDING AGREEMENT.—The Secretary may
4 pay a retention bonus to any health professional employed
5 by an organization providing health care services to Indi-
6 ans pursuant to a funding agreement under the Indian
7 Self-Determination and Education Assistance Act if such
8 health professional is serving in a position which the Sec-
9 retary determines is—
10 "(1) a position for which recruitment or reten-
11 tion is difficult; and
12 "(2) necessary for providing health care services
13 to Indians.
14 **"SEC. 120. NURSING RESIDENCY PROGRAM.**
15 "(a) ESTABLISHMENT.—The Secretary, acting
16 through the Service, shall establish a program to enable
17 Indians who are licensed practical nurses, licensed voca-
18 tional nurses, and registered nurses who are working in
19 an Indian health program (as defined in section
20 110(a)(2)(A)), and have done so for a period of not less
21 than 1 year, to pursue advanced training.
22 "(b) REQUIREMENT.—The program established
23 under subsection (a) shall include a combination of edu-
24 cation and work study in an Indian health program (as
25 defined in section 110(a)(2)(A)) leading to an associate

1 or bachelor's degree (in the case of a licensed practical
2 nurse or licensed vocational nurse) or a bachelor's degree
3 (in the case of a registered nurse) or an advanced degrees
4 in nursing and public health.

5 "(c) SERVICE OBLIGATION.—An individual who par-
6 ticipates in a program under subsection (a), where the
7 educational costs are paid by the Service, shall incur an
8 obligation to serve in an Indian health program for a pe-
9 riod of obligated service equal to the amount of time dur-
10 ing which the individual participates in such program. In
11 the event that the individual fails to complete such obli-
12 gated service, the United States shall be entitled to recover
13 from such individual an amount determined in accordance
14 with the formula specified in subsection (l) of section 110
15 in the manner provided for in such subsection.

16 **"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR**
17 **ALASKA.**

18 "(a) IN GENERAL.—Under the authority of the Act
19 of November 2, 1921 (25 U.S.C. 13; commonly known as
20 the Snyder Act), the Secretary shall maintain a Commu-
21 nity Health Aide Program in Alaska under which the
22 Service—

23 "(1) provides for the training of Alaska Natives
24 as health aides or community health practitioners;

1 "(2) uses such aides or practitioners in the pro-
2 vision of health care, health promotion, and disease
3 prevention services to Alaska Natives living in vil-
4 lages in rural Alaska; and
5 "(3) provides for the establishment of tele-
6 conferencing capacity in health clinics located in or
7 near such villages for use by community health aides
8 or community health practitioners.
9 "(b) ACTIVITIES.—The Secretary, acting through the
10 Community Health Aide Program under subsection (a),
11 shall—
12 "(1) using trainers accredited by the Program,
13 provide a high standard of training to community
14 health aides and community health practitioners to
15 ensure that such aides and practitioners provide
16 quality health care, health promotion, and disease
17 prevention services to the villages served by the Pro-
18 gram;
19 "(2) in order to provide such training, develop
20 a curriculum that—
21 "(A) combines education in the theory of
22 health care with supervised practical experience
23 in the provision of health care;
24 "(B) provides instruction and practical ex-
25 perience in the provision of acute care, emer-

1 gency care, health promotion, disease preven-
2 tion, and the efficient and effective manage-
3 ment of clinic pharmacies, supplies, equipment,
4 and facilities; and
5 "(C) promotes the achievement of the
6 health status objective specified in section 3(b);
7 "(3) establish and maintain a Community
8 Health Aide Certification Board to certify as com-
9 munity health aides or community health practition-
10 ers individuals who have successfully completed the
11 training described in paragraph (1) or who can dem-
12 onstrate equivalent experience;
13 "(4) develop and maintain a system which iden-
14 tifies the needs of community health aides and com-
15 munity health practitioners for continuing education
16 in the provision of health care, including the areas
17 described in paragraph (2)(B), and develop pro-
18 grams that meet the needs for such continuing edu-
19 cation;
20 "(5) develop and maintain a system that pro-
21 vides close supervision of community health aides
22 and community health practitioners; and
23 "(6) develop a system under which the work of
24 community health aides and community health prac-
25 titioners is reviewed and evaluated to assure the pro-

1 vision of quality health care, health promotion, and
2 disease prevention services.

3 **"SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.**

4 "Subject to Section 102, the Secretary, acting
5 through the Service, shall, through a funding agreement
6 or otherwise, provide training for Indians in the adminis-
7 tration and planning of tribal health programs.

8 **"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE**
9 **DEMONSTRATION PROJECT.**

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

14 "(b) PURPOSE.—It is the purpose of the health pro-
15 fessions demonstration project under this section to—

16 "(1) provide direct clinical and practical experi-
17 ence in a service area to health professions students
18 and residents from medical schools;

19 "(2) improve the quality of health care for Indi-
20 ans by assuring access to qualified health care pro-
21 fessionals; and

22 "(3) provide academic and scholarly opportuni-
23 ties for health professionals serving Indian people by
24 identifying and utilizing all academic and scholarly
25 resources of the region.

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

6 **"SEC. 124. SCHOLARSHIPS.**

7 "Scholarships and loan reimbursements provided to
8 individuals pursuant to this title shall be treated as 'quali-
9 fied scholarships' for purposes of section 117 of the Inter-
10 nal Revenue Code of 1986.

11 **"SEC. 125. NATIONAL HEALTH SERVICE CORPS.**

12 "(a) LIMITATIONS.—The Secretary shall not—
13 "(1) remove a member of the National Health
14 Services Corps from a health program operated by
15 Indian Health Service or by a tribe or tribal organi-
16 zation under a funding agreement with the Service
17 under the Indian Self-Determination and Education
18 Assistance Act, or by urban Indian organizations; or
19 "(2) withdraw the funding used to support such
20 a member;
21 unless the Secretary, acting through the Service, tribes or
22 tribal organization, has ensured that the Indians receiving
23 services from such member will experience no reduction
24 in services.

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

9 "(c) FULL TIME EQUIVALENT.—National Health
10 Service Corps scholars that qualify for the commissioned
11 corps in the Public Health Service shall be exempt from
12 the full time equivalent limitations of the National Health
13 Service Corps and the Service when such scholars serve
14 as commissioned corps officers in a health program oper-
15 ated by an Indian tribe or tribal organization under the
16 Indian Self-Determination and Education Assistance Act
17 or by an urban Indian organization.

18 **"SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION**
19 **DEMONSTRATION PROJECT.**

20 "(a) DEMONSTRATION PROJECTS.—The Secretary,
21 acting through the Service, may enter into contracts with,
22 or make grants to, accredited tribally controlled commu-
23 nity colleges, tribally controlled postsecondary vocational
24 institutions, and eligible accredited and accessible commu-

1 nity colleges to establish demonstration projects to develop
2 educational curricula for substance abuse counseling.
3 "(b) USE OF FUNDS.—Funds provided under this
4 section shall be used only for developing and providing
5 educational curricula for substance abuse counseling (in-
6 cluding paying salaries for instructors). Such curricula
7 may be provided through satellite campus programs.
8 "(c) TERM OF GRANT.—A contract entered into or
9 a grant provided under this section shall be for a period
10 of 1 year. Such contract or grant may be renewed for an
11 additional 1 year period upon the approval of the Sec-
12 retary.
13 "(d) REVIEW OF APPLICATIONS.—Not later than 180
14 days after the date of the enactment of this Act, the Sec-
15 retary, after consultation with Indian tribes and adminis-
16 trators of accredited tribally controlled community col-
17 leges, tribally controlled postsecondary vocational institu-
18 tions, and eligible accredited and accessible community
19 colleges, shall develop and issue criteria for the review and
20 approval of applications for funding (including applica-
21 tions for renewals of funding) under this section. Such cri-
22 teria shall ensure that demonstration projects established
23 under this section promote the development of the capacity
24 of such entities to educate substance abuse counselors.

1 "(e) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide such technical and other assistance as may be nec-
3 essary to enable grant recipients to comply with the provi-
4 sions of this section.

5 "(f) REPORT.—The Secretary shall submit to the
6 President, for inclusion in the report required to be sub-
7 mitted under section 801 for fiscal year 1999, a report
8 on the findings and conclusions derived from the dem-
9 onstration projects conducted under this section.

10 "(g) DEFINITIONS.—In this section:

11 "(1) EDUCATIONAL CURRICULUM.—The term
12 'educational curriculum' means 1 or more of the fol-
13 lowing:

14 "(A) Classroom education.

15 "(B) Clinical work experience.

16 "(C) Continuing education workshops.

17 "(2) TRIBALLY CONTROLLED COMMUNITY COL-
18 LEGE.—The term 'tribally controlled community col-
19 lege' has the meaning given such term in section
20 2(a)(4) of the Tribally Controlled Community Col-
21 lege Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

22 "(3) TRIBALLY CONTROLLED POSTSECONDARY
23 VOCATIONAL INSTITUTION.—The term 'tribally con-
24 trolled postsecondary vocational institution' has the
25 meaning given such term in section 390(2) of the

1 Tribally Controlled Vocational Institutions Support
2 Act of 1990 (20 U.S.C. 2397h(2)).

3 **"SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY**
4 **EDUCATION.**

5 "(a) STUDY AND LIST.—

6 "(1) IN GENERAL.—The Secretary and the Sec-
7 retary of the Interior in consultation with Indian
8 tribes and tribal organizations shall conduct a study
9 and compile a list of the types of staff positions
10 specified in subsection (b) whose qualifications in-
11 clude or should include, training in the identifica-
12 tion, prevention, education, referral or treatment of
13 mental illness, dysfunctional or self-destructive be-
14 havior.

15 "(2) POSITIONS.—The positions referred to in
16 paragraph (1) are—

17 "(A) staff positions within the Bureau of
18 Indian Affairs, including existing positions, in
19 the fields of—

20 "(i) elementary and secondary edu-
21 cation;

22 "(ii) social services, family and child
23 welfare;

24 "(iii) law enforcement and judicial
25 services; and

1 "(iv) alcohol and substance abuse;

2 "(B) staff positions within the Service; and

3 "(C) staff positions similar to those speci-
4 fied in subsection (b) and established and main-
5 tained by Indian tribes, tribal organizations,
6 and urban Indian organizations, including posi-
7 tions established pursuant to funding agree-
8 ments under the Indian Self-determination and
9 Education Assistance Act, and this Act.

10 "(3) TRAINING CRITERIA.—

11 "(A) IN GENERAL.—The appropriate Sec-
12 retary shall provide training criteria appropriate
13 to each type of position specified in subsection
14 (b)(1) and ensure that appropriate training has
15 been or will be provided to any individual in any
16 such position.

17 "(B) TRAINING.—With respect to any such
18 individual in a position specified pursuant to
19 subsection (b)(3), the respective Secretaries
20 shall provide appropriate training or provide
21 funds to an Indian tribe, tribal organization, or
22 urban Indian organization for the training of
23 appropriate individuals. In the case of a fund-
24 ing agreement, the appropriate Secretary shall

1 ensure that such training costs are included in
2 the funding agreement, if necessary.
3 "(4) CULTURAL RELEVANCY.—Position specific
4 training criteria shall be culturally relevant to Indi-
5 ans and Indian tribes and shall ensure that appro-
6 priate information regarding traditional health care
7 practices is provided.
8 "(5) COMMUNITY EDUCATION.—
9 "(A) DEVELOPMENT.—The Service shall
10 develop and implement, or on request of an In-
11 dian tribe or tribal organization, assist an In-
12 dian tribe or tribal organization, in developing
13 and implementing a program of community
14 education on mental illness.
15 "(B) TECHNICAL ASSISTANCE.—In carry-
16 ing out this paragraph, the Service shall, upon
17 the request of an Indian tribe or tribal organi-
18 zation, provide technical assistance to the In-
19 dian tribe or tribal organization to obtain and
20 develop community educational materials on the
21 identification, prevention, referral and treat-
22 ment of mental illness, dysfunctional and self-
23 destructive behavior.
24 "(b) STAFFING.—

1 "(1) IN GENERAL.—Not later than 90 days
2 after the date of enactment of the Act, the Director
3 of the Service shall develop a plan under which the
4 Service will increase the number of health care staff
5 that are providing mental health services by at least
6 500 positions within 5 years after such date of en-
7 actment, with at least 200 of such positions devoted
8 to child, adolescent, and family services. The alloca-
9 tion of such positions shall be subject to the provi-
10 sions of section 102(a).

11 "(2) IMPLEMENTATION.—The plan developed
12 under paragraph (1) shall be implemented under the
13 Act of November 2, 1921 (25 U.S.C. 13) (commonly
14 know as the 'Snyder Act').

15 **"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.**

16 "There are authorized to be appropriated such sums
17 as may be necessary for each fiscal year through fiscal
18 year 2012 to carry out this title.

19 **"TITLE II—HEALTH SERVICES**

20 **"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.**

21 "(a) IN GENERAL.—The Secretary may expend
22 funds, directly or under the authority of the Indian Self-
23 Determination and Education Assistance Act, that are ap-
24 propriated under the authority of this section, for the pur-
25 poses of—

1 "(1) eliminating the deficiencies in the health
2 status and resources of all Indian tribes;
3 "(2) eliminating backlogs in the provision of
4 health care services to Indians;
5 "(3) meeting the health needs of Indians in an
6 efficient and equitable manner;
7 "(4) eliminating inequities in funding for both
8 direct care and contract health service programs;
9 and –
10 "(5) augmenting the ability of the Service to
11 meet the following health service responsibilities with
12 respect to those Indian tribes with the highest levels
13 of health status and resource deficiencies:
14 "(A) clinical care, including inpatient care,
15 outpatient care (including audiology, clinical eye
16 and vision care), primary care, secondary and
17 tertiary care, and long term care;
18 "(B) preventive health, including mam-
19 mography and other cancer screening in accord-
20 ance with section 207;
21 "(C) dental care;
22 "(D) mental health, including community
23 mental health services, inpatient mental health
24 services, dormitory mental health services,
25 therapeutic and residential treatment centers,

1 and training of traditional health care practi-
2 tioners;
3 "(E) emergency medical services;
4 "(F) treatment and control of, and reha-
5 bilitative care related to, alcoholism and drug
6 abuse (including fetal alcohol syndrome) among
7 Indians;
8 "(G) accident prevention programs;
9 "(H) home health care;
10 "(I) community health representatives;
11 "(J) maintenance and repair; and
12 "(K) traditional health care practices.
13 "(b) USE OF FUNDS.—
14 "(1) LIMITATION.—Any funds appropriated
15 under the authority of this section shall not be used
16 to offset or limit any other appropriations made to
17 the Service under this Act, the Act of November 2,
18 1921 (25 U.S.C. 13) (commonly known as the 'Sny-
19 der Act'), or any other provision of law.
20 "(2) ALLOCATION.—
21 "(A) IN GENERAL.—Funds appropriated
22 under the authority of this section shall be allo-
23 cated to service units or Indian tribes or tribal
24 organizations. The funds allocated to each tribe,
25 tribal organization, or service unit under this

1 subparagraph shall be used to improve the
2 health status and reduce the resource deficiency
3 of each tribe served by such service unit, tribe
4 or tribal organization.

5 "(B) APPORTIONMENT.—The apportion-
6 ment of funds allocated to a service unit, tribe
7 or tribal organization under subparagraph (A)
8 among the health service responsibilities de-
9 scribed in subsection (a)(4) shall be determined
10 by the Service in consultation with, and with
11 the active participation of, the affected Indian
12 tribes in accordance with this section and such
13 rules as may be established under title VIII.

14 "(c) HEALTH STATUS AND RESOURCE DEFI-
15 CIENCY.—In this section:

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

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

21 "(B) the Indian tribe or tribal organization
22 does not have available to it the health re-
23 sources it needs, taking into account the actual
24 cost of providing health care services given local

1 geographic, climatic, rural, or other cir-
2 cumstances.
3 "(2) RESOURCES.—The health resources avail-
4 able to an Indian tribe or tribal organization shall
5 include health resources provided by the Service as
6 well as health resources used by the Indian Tribe or
7 tribal organization, including services and financing
8 systems provided by any Federal programs, private
9 insurance, and programs of State or local govern-
10 ments.
11 "(3) REVIEW OF DETERMINATION.—The Sec-
12 retary shall establish procedures which allow any In-
13 dian tribe or tribal organization to petition the Sec-
14 retary for a review of any determination of the ex-
15 tent of the health status and resource deficiency of
16 such tribe or tribal organization.
17 "(d) ELIGIBILITY.—Programs administered by any
18 Indian tribe or tribal organization under the authority of
19 the Indian Self-Determination and Education Assistance
20 Act shall be eligible for funds appropriated under the au-
21 thority of this section on an equal basis with programs
22 that are administered directly by the Service.
23 "(e) REPORT.—Not later than the date that is 3
24 years after the date of enactment of this Act, the Sec-
25 retary shall submit to the Congress the current health sta-

1 tus and resource deficiency report of the Service for each
2 Indian tribe or service unit, including newly recognized or
3 acknowledged tribes. Such report shall set out—
4 "(1) the methodology then in use by the Service
5 for determining tribal health status and resource de-
6 ficiencies, as well as the most recent application of
7 that methodology;
8 "(2) the extent of the health status and re-
9 source deficiency of each Indian tribe served by the
10 Service;
11 "(3) the amount of funds necessary to eliminate
12 the health status and resource deficiencies of all In-
13 dian tribes served by the Service; and
14 "(4) an estimate of—
15 "(A) the amount of health service funds
16 appropriated under the authority of this Act, or
17 any other Act, including the amount of any
18 funds transferred to the Service, for the preced-
19 ing fiscal year which is allocated to each service
20 unit, Indian tribe, or comparable entity;
21 "(B) the number of Indians eligible for
22 health services in each service unit or Indian
23 tribe or tribal organization; and
24 "(C) the number of Indians using the
25 Service resources made available to each service

1 unit or Indian tribe or tribal organization, and,
2 to the extent available, information on the wait-
3 ing lists and number of Indians turned away for
4 services due to lack of resources.

5 "(f) BUDGETARY RULE.—Funds appropriated under
6 the authority of this section for any fiscal year shall be
7 included in the base budget of the Service for the purpose
8 of determining appropriations under this section in subse-
9 quent fiscal years.

10 "(g) RULE OF CONSTRUCTION.—Nothing in this sec-
11 tion shall be construed to diminish the primary respon-
12 sibility of the Service to eliminate existing backlogs in
13 unmet health care needs or to discourage the Service from
14 undertaking additional efforts to achieve equity among In-
15 dian tribes and tribal organizations.

16 "(h) DESIGNATION.—Any funds appropriated under
17 the authority of this section shall be designated as the 'In-
18 dian Health Care Improvement Fund'.

19 **"SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.**

20 "(a) ESTABLISHMENT.—

21 "(1) IN GENERAL.—There is hereby established
22 an Indian Catastrophic Health Emergency Fund (re-
23 ferred to in this section as the 'CHEF') consisting
24 of—

1 "(A) the amounts deposited under sub-
2 section (d); and
3 "(B) any amounts appropriated to the
4 CHEF under this Act.
5 "(2) ADMINISTRATION.—The CHEF shall be
6 administered by the Secretary solely for the purpose
7 of meeting the extraordinary medical costs associ-
8 ated with the treatment of victims of disasters or
9 catastrophic illnesses who are within the responsibil-
10 ity of the Service.
11 "(3) EQUITABLE ALLOCATION.—The CHEF
12 shall be equitably allocated, apportioned or delegated
13 on a service unit or area office basis, based upon a
14 formula to be developed by the Secretary in con-
15 sultation with the Indian tribes and tribal organiza-
16 tions through negotiated rulemaking under title
17 VIII. Such formula shall take into account the
18 added needs of service areas which are contract
19 health service dependent.
20 "(4) NOT SUBJECT TO CONTRACT OR
21 GRANT.—No part of the CHEF or its adminis-
22 tration shall be subject to contract or grant
23 under any law, including the Indian Self-Deter-
24 mination and Education Assistance Act.

1 "(5) ADMINISTRATION.—Amounts pro-
2 vided from the CHEF shall be administered by
3 the area offices based upon priorities deter-
4 mined by the Indian tribes and tribal organiza-
5 tions within each service area, including a con-
6 sideration of the needs of Indian tribes and
7 tribal organizations which are contract health
8 service-dependent.
9 "(b) REQUIREMENTS.—The Secretary shall, through
10 the negotiated rulemaking process under title VIII, pro-
11 mulgate regulations consistent with the provisions of this
12 section—
13 "(1) establish a definition of disasters and cata-
14 strophic illnesses for which the cost of treatment
15 provided under contract would qualify for payment
16 from the CHEF;
17 "(2) provide that a service unit, Indian tribe, or
18 tribal organization shall not be eligible for reim-
19 bursement for the cost of treatment from the CHEF
20 until its cost of treatment for any victim of such a
21 catastrophic illness or disaster has reached a certain
22 threshold cost which the Secretary shall establish
23 at—
24 "(A) for 1999, not less than $19,000; and

1 "(B) for any subsequent year, not less
2 than the threshold cost of the previous year in-
3 creased by the percentage increase in the medi-
4 cal care expenditure category of the consumer
5 price index for all urban consumers (United
6 States city average) for the 12-month period
7 ending with December of the previous year;
8 "(3) establish a procedure for the reimburse-
9 ment of the portion of the costs incurred by—
10 "(A) service units, Indian tribes, or tribal
11 organizations, or facilities of the Service; or
12 "(B) non-Service facilities or providers
13 whenever otherwise authorized by the Service;
14 in rendering treatment that exceeds threshold cost
15 described in paragraph (2);
16 "(4) establish a procedure for payment from
17 the CHEF in cases in which the exigencies of the
18 medical circumstances warrant treatment prior to
19 the authorization of such treatment by the Service;
20 and
21 "(5) establish a procedure that will ensure that
22 no payment shall be made from the CHEF to any
23 provider of treatment to the extent that such pro-
24 vider is eligible to receive payment for the treatment
25 from any other Federal, State, local, or private

1 source of reimbursement for which the patient is eli-
2 gible.
3 "(c) LIMITATION.—Amounts appropriated to the
4 CHEF under this section shall not be used to offset or
5 limit appropriations made to the Service under the author-
6 ity of the Act of November 2, 1921 (25 U.S.C. 13) (com-
7 monly known as the Snyder Act) or any other law.
8 "(d) DEPOSITS.—There shall be deposited into the
9 CHEF all reimbursements to which the Service is entitled
10 from any Federal, State, local, or private source (including
11 third party insurance) by reason of treatment rendered to
12 any victim of a disaster or catastrophic illness the cost
13 of which was paid from the CHEF.
14 **"SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION**
15 **SERVICES.**
16 "(a) FINDINGS.—Congress finds that health pro-
17 motion and disease prevention activities will—
18 "(1) improve the health and well-being of Indi-
19 ans; and
20 "(2) reduce the expenses for health care of In-
21 dians.
22 "(b) PROVISION OF SERVICES.—The Secretary, act-
23 ing through the Service and through Indian tribes and
24 tribal organizations, shall provide health promotion and

1 disease prevention services to Indians so as to achieve the
2 health status objective set forth in section 3(b).
3 "(c) DISEASE PREVENTION AND HEALTH PRO-
4 MOTION.—In this section:
5 "(1) DISEASE PREVENTION.—The term 'disease
6 prevention' means the reduction, limitation, and pre-
7 vention of disease and its complications, and the re-
8 duction in the consequences of such diseases,
9 including—
10 "(A) controlling—
11 "(i) diabetes;
12 "(ii) high blood pressure;
13 "(iii) infectious agents;
14 "(iv) injuries;
15 "(v) occupational hazards and disabil-
16 ities;
17 "(vi) sexually transmittable diseases;
18 and
19 "(vii) toxic agents; and
20 "(B) providing—
21 "(i) for the fluoridation of water; and
22 "(ii) immunizations.
23 "(2) HEALTH PROMOTION.—The term 'health
24 promotion' means fostering social, economic, envi-

1 ronmental, and personal factors conducive to health,
2 including—
3 "(A) raising people's awareness about
4 health matters and enabling them to cope with
5 health problems by increasing their knowledge
6 and providing them with valid information;
7 "(B) encouraging adequate and appro-
8 priate diet, exercise, and sleep;
9 "(C) promoting education and work in con-
10 formity with physical and mental capacity;
11 "(E) making available suitable housing,
12 safe water, and sanitary facilities;
13 "(F) improving the physical economic, cul-
14 tural, psychological, and social environment;
15 "(G) promoting adequate opportunity for
16 spiritual, religious, and traditional practices;
17 and
18 "(H) adequate and appropriate programs
19 including—
20 "(i) abuse prevention (mental and
21 physical);
22 "(iii) community health;
23 "(iv) community safety;
24 "(v) consumer health education;
25 "(vi) diet and nutrition;

1 "(vii) disease prevention (commu-
2 nicable, immunizations, HIV/AIDS);
3 "(viii) environmental health;
4 "(ix) exercise and physical fitness;
5 "(x) fetal alcohol disorders;
6 "(xi) first aid and CPR education;
7 "(xii) human growth and develop-
8 ment;
9 "(xiii) injury prevention and personal
10 safety;
11 "(xiv) mental health (emotional, self-
12 worth);
13 "(xv) personal health and wellness
14 practices;
15 "(xvi) personal capacity building;
16 "(xvii) prenatal, pregnancy, and in-
17 fant care;
18 "(xviii) psychological well being;
19 "(xix) reproductive health (family
20 planning);
21 "(xx) safe and adequate water;
22 "(xxi) safe housing;
23 "(xxii) safe work environments;
24 "(xxiii) stress control;
25 "(xxiv) substance abuse;

1 "(xxv) sanitary facilities;

2 "(xxvi) tobacco use cessation and re-

3 duction;

4 "(xxvii) violence prevention; and

5 "(xxviii) such other activities identi-

6 fied by the Service, an Indian tribe or trib-

7 al organization, to promote the achieve-

8 ment of the objective described in section

9 3(b).

10 "(d) EVALUATION.—The Secretary, after obtaining

11 input from affected Indian tribes and tribal organizations,

12 shall submit to the President for inclusion in each state-

13 ment which is required to be submitted to Congress under

14 section 801 an evaluation of—

15 "(1) the health promotion and disease preven-

16 tion needs of Indians;

17 "(2) the health promotion and disease preven-

18 tion activities which would best meet such needs;

19 "(3) the internal capacity of the Service to meet

20 such needs; and

21 "(4) the resources which would be required to

22 enable the Service to undertake the health promotion

23 and disease prevention activities necessary to meet

24 such needs.

1 **"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CON-**
2 **TROL.**

3 "(a) DETERMINATION.—The Secretary, in consulta-
4 tion with Indian tribes and tribal organizations, shall
5 determine—

6 "(1) by tribe, tribal organization, and service
7 unit of the Service, the prevalence of, and the types
8 of complications resulting from, diabetes among In-
9 dians; and

10 "(2) based on paragraph (1), the measures (in-
11 cluding patient education) each service unit should
12 take to reduce the prevalence of, and prevent, treat,
13 and control the complications resulting from, diabe-
14 tes among Indian tribes within that service unit.

15 "(b) SCREENING.—The Secretary shall screen each
16 Indian who receives services from the Service for diabetes
17 and for conditions which indicate a high risk that the indi-
18 vidual will become diabetic. Such screening may be done
19 by an Indian tribe or tribal organization operating health
20 care programs or facilities with funds from the Service
21 under the Indian Self-Determination and Education As-
22 sistance Act.

23 "(c) CONTINUED FUNDING.—The Secretary shall
24 continue to fund, through fiscal year 2012, each effective
25 model diabetes project in existence on the date of the en-
26 actment of this Act and such other diabetes programs op-

1 erated by the Secretary or by Indian tribes and tribal or-
2 ganizations and any additional programs added to meet
3 existing diabetes needs. Indian tribes and tribal organiza-
4 tions shall receive recurring funding for the diabetes pro-
5 grams which they operate pursuant to this section. Model
6 diabetes projects shall consult, on a regular basis, with
7 tribes and tribal organizations in their regions regarding
8 diabetes needs and provide technical expertise as needed.
9 "(d) DIALYSIS PROGRAMS.—The Secretary shall pro-
10 vide funding through the Service, Indian tribes and tribal
11 organizations to establish dialysis programs, including
12 funds to purchase dialysis equipment and provide nec-
13 essary staffing.
14 "(e) OTHER ACTIVITIES.—The Secretary shall, to the
15 extent funding is available—
16 "(1) in each area office of the Service, consult
17 with Indian tribes and tribal organizations regarding
18 programs for the prevention, treatment, and control
19 of diabetes;
20 "(2) establish in each area office of the Service
21 a registry of patients with diabetes to track the
22 prevalence of diabetes and the complications from
23 diabetes in that area; and
24 "(3) ensure that data collected in each area of-
25 fice regarding diabetes and related complications

1 among Indians is disseminated to tribes, tribal orga-
2 nizations, and all other area offices.

3 **"SEC. 205. SHARED SERVICES.**

4 "(a) IN GENERAL.—The Secretary, acting through
5 the Service and notwithstanding any other provision of
6 law, is authorized to enter into funding agreements or
7 other arrangements with Indian tribes or tribal organiza-
8 tions for the delivery of long-term care and similar services
9 to Indians. Such projects shall provide for the sharing of
10 staff or other services between a Service or tribal facility
11 and a long-term care or other similar facility owned and
12 operated (directly or through a funding agreement) by
13 such Indian tribe or tribal organization.

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

17 "(1) may, at the request of the Indian tribe or
18 tribal organization, delegate to such tribe or tribal
19 organization such powers of supervision and control
20 over Service employees as the Secretary deems nec-
21 essary to carry out the purposes of this section;

22 "(2) shall provide that expenses (including sala-
23 ries) relating to services that are shared between the
24 Service and the tribal facility be allocated propor-

1 tionately between the Service and the tribe or tribal
2 organization; and
3 "(3) may authorize such tribe or tribal organi-
4 zation to construct, renovate, or expand a long-term
5 care or other similar facility (including the construc-
6 tion of a facility attached to a Service facility).
7 "(c) TECHNICAL ASSISTANCE.—The Secretary shall
8 provide such technical and other assistance as may be nec-
9 essary to enable applicants to comply with the provisions
10 of this section.
11 "(d) USE OF EXISTING FACILITIES.—The Secretary
12 shall encourage the use for long-term or similar care of
13 existing facilities that are under-utilized or allow the use
14 of swing beds for such purposes.
15 **"SEC. 206. HEALTH SERVICES RESEARCH.**
16 "(a) FUNDING.—The Secretary shall make funding
17 available for research to further the performance of the
18 health service responsibilities of the Service, Indian tribes,
19 and tribal organizations and shall coordinate the activities
20 of other Agencies within the Department to address these
21 research needs.
22 "(b) ALLOCATION.—Funding under subsection (a)
23 shall be allocated equitably among the area offices. Each
24 area office shall award such funds competitively within
25 that area.

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

7 "(d) USE.—Funds received under this section may
8 be used for both clinical and non-clinical research by In-
9 dian tribes and tribal organizations and shall be distrib-
10 uted to the area offices. Such area offices may make
11 grants using such funds within each area.

12 **"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREEN-**
13 **ING.**

14 "The Secretary, through the Service or through In-
15 dian tribes or tribal organizations, shall provide for the
16 following screening:

17 "(1) Mammography (as defined in section
18 1861(jj) of the Social Security Act) for Indian
19 women at a frequency appropriate to such women
20 under national standards, and under such terms and
21 conditions as are consistent with standards estab-
22 lished by the Secretary to assure the safety and ac-
23 curacy of screening mammography under part B of
24 title XVIII of the Social Security Act.

1 "(2) Other cancer screening meeting national
2 standards.

3 **"SEC. 208. PATIENT TRAVEL COSTS.**

4 "The Secretary, acting through the Service, Indian
5 tribes and tribal organizations shall provide funds for the
6 following patient travel costs, including appropriate and
7 necessary qualified escorts, associated with receiving
8 health care services provided (either through direct or con-
9 tract care or through funding agreements entered into
10 pursuant to the Indian Self-Determination and Education
11 Assistance Act) under this Act:

12 "(1) Emergency air transportation and non-
13 emergency air transportation where ground trans-
14 portation is infeasible.

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

17 "(3) Transportation by such other means as
18 may be available and required when air or motor ve-
19 hicle transportation is not available.

20 **"SEC. 209. EPIDEMIOLOGY CENTERS.**

21 "(a) ESTABLISHMENT.—

22 "(1) IN GENERAL.—In addition to those centers
23 operating 1 day prior to the date of enactment of
24 this Act, (including those centers for which funding
25 is currently being provided through funding agree-

1 ments under the Indian Self-Determination and
2 Education Assistance Act), the Secretary shall, not
3 later than 180 days after such date of enactment,
4 establish and fund an epidemiology center in each
5 service area which does not have such a center to
6 carry out the functions described in paragraph (2).
7 Any centers established under the preceding sen-
8 tence may be operated by Indian tribes or tribal or-
9 ganizations pursuant to funding agreements under
10 the Indian Self-Determination and Education Assist-
11 ance Act, but funding under such agreements may
12 not be divisible.

13 "(2) FUNCTIONS.—In consultation with and
14 upon the request of Indian tribes, tribal organiza-
15 tions and urban Indian organizations, each area epi-
16 demiology center established under this subsection
17 shall, with respect to such area shall—

18 "(A) collect data related to the health sta-
19 tus objective described in section 3(b), and
20 monitor the progress that the Service, Indian
21 tribes, tribal organizations, and urban Indian
22 organizations have made in meeting such health
23 status objective;

1 "(B) evaluate existing delivery systems,
2 data systems, and other systems that impact
3 the improvement of Indian health;
4 "(C) assist Indian tribes, tribal organiza-
5 tions, and urban Indian organizations in identi-
6 fying their highest priority health status objec-
7 tives and the services needed to achieve such
8 objectives, based on epidemiological data;
9 "(D) make recommendations for the tar-
10 geting of services needed by tribal, urban, and
11 other Indian communities;
12 "(E) make recommendations to improve
13 health care delivery systems for Indians and
14 urban Indians;
15 "(F) provide requested technical assistance
16 to Indian Tribes and urban Indian organiza-
17 tions in the development of local health service
18 priorities and incidence and prevalence rates of
19 disease and other illness in the community; and
20 "(G) provide disease surveillance and assist
21 Indian tribes, tribal organizations, and urban
22 Indian organizations to promote public health.
23 "(3) TECHNICAL ASSISTANCE.—The director of
24 the Centers for Disease Control and Prevention shall

1 provide technical assistance to the centers in carry-
2 ing out the requirements of this subsection.
3 "(b) FUNDING.—The Secretary may make funding
4 available to Indian tribes, tribal organizations, and eligible
5 intertribal consortia or urban Indian organizations to con-
6 duct epidemiological studies of Indian communities.

7 **"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
8 **PROGRAMS.**

9 "(a) IN GENERAL.—The Secretary, acting through
10 the Service, shall provide funding to Indian tribes, tribal
11 organizations, and urban Indian organizations to develop
12 comprehensive school health education programs for chil-
13 dren from preschool through grade 12 in schools for the
14 benefit of Indian and urban Indian children.
15 "(b) USE OF FUNDS.—Funds awarded under this
16 section may be used to—
17 "(1) develop and implement health education
18 curricula both for regular school programs and after
19 school programs;
20 "(2) train teachers in comprehensive school
21 health education curricula;
22 "(3) integrate school-based, community-based,
23 and other public and private health promotion ef-
24 forts;

1 "(4) encourage healthy, tobacco-free school en-
2 vironments;
3 "(5) coordinate school-based health programs
4 with existing services and programs available in the
5 community;
6 "(6) develop school programs on nutrition edu-
7 cation, personal health, oral health, and fitness;
8 "(7) develop mental health wellness programs;
9 "(8) develop chronic disease prevention pro-
10 grams;
11 "(9) develop substance abuse prevention pro-
12 grams;
13 "(10) develop injury prevention and safety edu-
14 cation programs;
15 "(11) develop activities for the prevention and
16 control of communicable diseases;
17 "(12) develop community and environmental
18 health education programs that include traditional
19 health care practitioners;
20 "(13) carry out violence prevention activities;
21 and
22 "(14) carry out activities relating to such other
23 health issues as are appropriate.
24 "(c) TECHNICAL ASSISTANCE.—The Secretary shall,
25 upon request, provide technical assistance to Indian tribes,

1 tribal organization and urban Indian organizations in the
2 development of comprehensive health education plans, and
3 the dissemination of comprehensive health education ma-
4 terials and information on existing health programs and
5 resources.

6 "(d) CRITERIA.—The Secretary, in consultation with
7 Indian tribes tribal organizations, and urban Indian orga-
8 nizations shall establish criteria for the review and ap-
9 proval of applications for funding under this section.

10 "(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION
11 PROGRAM.—

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

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

21 "(A) school programs on nutrition edu-
22 cation, personal health, oral health, and fitness;

23 "(B) mental health wellness programs;

24 "(C) chronic disease prevention programs;

1 "(D) substance abuse prevention pro-
2 grams;
3 "(E) injury prevention and safety edu-
4 cation programs; and
5 "(F) activities for the prevention and con-
6 trol of communicable diseases.
7 "(3) TRAINING AND COORDINATION.—The Sec-
8 retary of the Interior shall—
9 "(A) provide training to teachers in com-
10 prehensive school health education curricula;
11 "(B) ensure the integration and coordina-
12 tion of school-based programs with existing
13 services and health programs available in the
14 community; and
15 "(C) encourage healthy, tobacco-free school
16 environments.
17 **"SEC. 211. INDIAN YOUTH PROGRAM.**
18 "(a) IN GENERAL.—The Secretary, acting through
19 the Service, is authorized to provide funding to Indian
20 tribes, tribal organizations, and urban Indian organiza-
21 tions for innovative mental and physical disease prevention
22 and health promotion and treatment programs for Indian
23 and urban Indian preadolescent and adolescent youths.
24 "(b) USE OF FUNDS.—

1 "(1) IN GENERAL.—Funds made available
2 under this section may be used to—
3 "(A) develop prevention and treatment
4 programs for Indian youth which promote men-
5 tal and physical health and incorporate cultural
6 values, community and family involvement, and
7 traditional health care practitioners; and
8 "(B) develop and provide community train-
9 ing and education.
10 "(2) LIMITATION.—Funds made available
11 under this section may not be used to provide serv-
12 ices described in section 707(c).
13 "(c) REQUIREMENTS.—The Secretary shall—
14 "(1) disseminate to Indian tribes, tribal organi-
15 zations, and urban Indian organizations information
16 regarding models for the delivery of comprehensive
17 health care services to Indian and urban Indian ado-
18 lescents;
19 "(2) encourage the implementation of such
20 models; and
21 "(3) at the request of an Indian tribe, tribal or-
22 ganization, or urban Indian organization, provide
23 technical assistance in the implementation of such
24 models.

1 "(d) CRITERIA.—The Secretary, in consultation with
2 Indian tribes, tribal organization, and urban Indian orga-
3 nizations, shall establish criteria for the review and ap-
4 proval of applications under this section.

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

7 "(a) IN GENERAL.—The Secretary, acting through
8 the Service after consultation with Indian tribes, tribal or-
9 ganizations, urban Indian organizations, and the Centers
10 for Disease Control and Prevention, may make funding
11 available to Indian tribes and tribal organizations for—
12 "(1) projects for the prevention, control, and
13 elimination of communicable and infectious diseases,
14 including tuberculosis, hepatitis, HIV, respiratory
15 syncitial virus, hanta virus, sexually transmitted dis-
16 eases, and H. Pylori;
17 "(2) public information and education programs
18 for the prevention, control, and elimination of com-
19 municable and infectious diseases; and
20 "(3) education, training, and clinical skills im-
21 provement activities in the prevention, control, and
22 elimination of communicable and infectious diseases
23 for health professionals, including allied health pro-
24 fessionals.

1 "(b) REQUIREMENT OF APPLICATION.—The Sec-
2 retary may provide funds under subsection (a) only if an
3 application or proposal for such funds is submitted.
4 "(c) TECHNICAL ASSISTANCE AND REPORT.—In car-
5 rying out this section, the Secretary—
6 "(1) may, at the request of an Indian tribe or
7 tribal organization, provide technical assistance; and
8 "(2) shall prepare and submit, biennially, a re-
9 port to Congress on the use of funds under this sec-
10 tion and on the progress made toward the preven-
11 tion, control, and elimination of communicable and
12 infectious diseases among Indians and urban Indi-
13 ans.
14 **"SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERV-**
15 **ICES.**
16 "(a) IN GENERAL.—The Secretary, acting through
17 the Service, Indian tribes, and tribal organizations, may
18 provide funding under this Act to meet the objective set
19 forth in section 3 through health care related services and
20 programs not otherwise described in this Act. Such serv-
21 ices and programs shall include services and programs re-
22 lated to—
23 "(1) hospice care and assisted living;
24 "(2) long-term health care;
25 "(3) home- and community-based services;

1 "(4) public health functions; and

2 "(5) traditional health care practices.

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

12 "(c) DEFINITIONS.—In this section:

13 "(1) HOME- AND COMMUNITY-BASED SERV-
14 ICES.—The term 'home- and community-based serv-
15 ices' means 1 or more of the following:

16 "(A) Homemaker/home health aide serv-
17 ices.

18 "(B) Chore services.

19 "(C) Personal care services.

20 "(D) Nursing care services provided out-
21 side of a nursing facility by, or under the super-
22 vision of, a registered nurse.

23 "(E) Training for family members.

24 "(F) Adult day care.

1 "(G) Such other home- and community-
2 based services as the Secretary or a tribe or
3 tribal organization may approve.
4 "(2) HOSPICE CARE.—The term 'hospice care'
5 means the items and services specified in subpara-
6 graphs (A) through (H) of section 1861(dd)(1) of
7 the Social Security Act (42 U.S.C. 1395x(dd)(1)),
8 and such other services which an Indian tribe or
9 tribal organization determines are necessary and ap-
10 propriate to provide in furtherance of such care.
11 "(3) PUBLIC HEALTH FUNCTIONS.—The term
12 'public health functions' means public health related
13 programs, functions, and services including assess-
14 ments, assurances, and policy development that In-
15 dian tribes and tribal organizations are authorized
16 and encouraged, in those circumstances where it
17 meets their needs, to carry out by forming collabo-
18 rative relationships with all levels of local, State, and
19 Federal governments.

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

21 "The Secretary acting through the Service, Indian
22 tribes, tribal organizations, and urban Indian organiza-
23 tions shall provide funding to monitor and improve the
24 quality of health care for Indian women of all ages
25 through the planning and delivery of programs adminis-

1 tered by the Service, in order to improve and enhance the
2 treatment models of care for Indian women.

3 **"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZ-**
4 **ARDS.**

5 "(a) STUDY AND MONITORING PROGRAMS.—The
6 Secretary and the Service shall, in conjunction with other
7 appropriate Federal agencies and in consultation with con-
8 cerned Indian tribes and tribal organizations, conduct a
9 study and carry out ongoing monitoring programs to de-
10 termine the trends that exist in the health hazards posed
11 to Indian miners and to Indians on or near Indian reserva-
12 tions and in Indian communities as a result of environ-
13 mental hazards that may result in chronic or life-threaten-
14 ing health problems. Such hazards include nuclear re-
15 source development, petroleum contamination, and con-
16 tamination of the water source or of the food chain. Such
17 study (and any reports with respect to such study) shall
18 include—

19 "(1) an evaluation of the nature and extent of
20 health problems caused by environmental hazards
21 currently exhibited among Indians and the causes of
22 such health problems;

23 "(2) an analysis of the potential effect of ongo-
24 ing and future environmental resource development
25 on or near Indian reservations and communities in-

1 cluding the cumulative effect of such development
2 over time on health;
3 "(3) an evaluation of the types and nature of
4 activities, practices, and conditions causing or affect-
5 ing such health problems including uranium mining
6 and milling, uranium mine tailing deposits, nuclear
7 power plant operation and construction, and nuclear
8 waste disposal, oil and gas production or transpor-
9 tation on or near Indian reservations or commu-
10 nities, and other development that could affect the
11 health of Indians and their water supply and food
12 chain;
13 "(4) a summary of any findings or rec-
14 ommendations provided in Federal and State stud-
15 ies, reports, investigations, and inspections during
16 the 5 years prior to the date of the enactment of
17 this Act that directly or indirectly relate to the ac-
18 tivities, practices, and conditions affecting the health
19 or safety of such Indians; and
20 "(5) a description of the efforts that have been
21 made by Federal and State agencies and resource
22 and economic development companies to effectively
23 carry out an education program for such Indians re-
24 garding the health and safety hazards of such devel-
25 opment.

1 "(b) DEVELOPMENT OF HEALTH CARE PLANS.—
2 Upon the completion of the study under subsection (a),
3 the Secretary and the Service shall take into account the
4 results of such study and, in consultation with Indian
5 tribes and tribal organizations, develop a health care plan
6 to address the health problems that were the subject of
7 such study. The plans shall include—
8 "(1) methods for diagnosing and treating Indi-
9 ans currently exhibiting such health problems;
10 "(2) preventive care and testing for Indians
11 who may be exposed to such health hazards, includ-
12 ing the monitoring of the health of individuals who
13 have or may have been exposed to excessive amounts
14 of radiation, or affected by other activities that have
15 had or could have a serious impact upon the health
16 of such individuals; and
17 "(3) a program of education for Indians who,
18 by reason of their work or geographic proximity to
19 such nuclear or other development activities, may ex-
20 perience health problems.
21 "(c) SUBMISSION TO CONGRESS.—
22 "(1) GENERAL REPORT.—Not later than 18
23 months after the date of enactment of this Act, the
24 Secretary and the Service shall submit to Congress

1 a report concerning the study conducted under sub-
2 section (a).
3 "(2) HEALTH CARE PLAN REPORT.—Not later
4 than 1 year after the date on which the report under
5 paragraph (1) is submitted to Congress, the Sec-
6 retary and the Service shall submit to Congress the
7 health care plan prepared under subsection (b).
8 Such plan shall include recommended activities for
9 the implementation of the plan, as well as an evalua-
10 tion of any activities previously undertaken by the
11 Service to address the health problems involved.
12 "(d) TASK FORCE.—
13 "(1) ESTABLISHED.—There is hereby estab-
14 lished an Intergovernmental Task Force (referred to
15 in this section as the 'task force') that shall be com-
16 posed of the following individuals (or their des-
17 ignees):
18 "(A) The Secretary of Energy.
19 "(B) The Administrator of the Environ-
20 mental Protection Agency.
21 "(C) The Director of the Bureau of Mines.
22 "(D) The Assistant Secretary for Occupa-
23 tional Safety and Health.
24 "(E) The Secretary of the Interior.

1 "(2) DUTIES.—The Task Force shall identify
2 existing and potential operations related to nuclear
3 resource development or other environmental haz-
4 ards that affect or may affect the health of Indians
5 on or near an Indian reservation or in an Indian
6 community, and enter into activities to correct exist-
7 ing health hazards and ensure that current and fu-
8 ture health problems resulting from nuclear resource
9 or other development activities are minimized or re-
10 duced.
11 "(3) ADMINISTRATIVE PROVISIONS.—The Sec-
12 retary shall serve as the chairperson of the Task
13 Force. The Task Force shall meet at least twice
14 each year. Each member of the Task Force shall
15 furnish necessary assistance to the Task Force.
16 "(e) PROVISION OF APPROPRIATE MEDICAL CARE.—
17 In the case of any Indian who—
18 "(1) as a result of employment in or near a
19 uranium mine or mill or near any other environ-
20 mental hazard, suffers from a work related illness or
21 condition;
22 "(2) is eligible to receive diagnosis and treat-
23 ment services from a Service facility; and
24 "(3) by reason of such Indian's employment, is
25 entitled to medical care at the expense of such mine

1 or mill operator or entity responsible for the environ-
2 mental hazard;
3 the Service shall, at the request of such Indian, render
4 appropriate medical care to such Indian for such illness
5 or condition and may recover the costs of any medical care
6 so rendered to which such Indian is entitled at the expense
7 of such operator or entity from such operator or entity.
8 Nothing in this subsection shall affect the rights of such
9 Indian to recover damages other than such costs paid to
10 the Service from the employer for such illness or condition.

11 **"SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DE-**
12 **LIVERY AREA.**

13 "(a) IN GENERAL.—For fiscal years beginning with
14 the fiscal year ending September 30, 1983, and ending
15 with the fiscal year ending September 30, 2012, the State
16 of Arizona shall be designated as a contract health service
17 delivery area by the Service for the purpose of providing
18 contract health care services to members of federally rec-
19 ognized Indian Tribes of Arizona.

20 "(b) LIMITATION.—The Service shall not curtail any
21 health care services provided to Indians residing on Fed-
22 eral reservations in the State of Arizona if such curtail-
23 ment is due to the provision of contract services in such
24 State pursuant to the designation of such State as a con-

1 tract health service delivery area pursuant to subsection
2 (a).

3 **"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEM-**
4 **ONSTRATION PROGRAM.**

5 "(a) IN GENERAL.—The Secretary may fund a pro-
6 gram that utilizes the California Rural Indian Health
7 Board as a contract care intermediary to improve the ac-
8 cessibility of health services to California Indians.

9 "(b) REIMBURSEMENT OF BOARD.—

10 "(1) AGREEMENT.—The Secretary shall enter
11 into an agreement with the California Rural Indian
12 Health Board to reimburse the Board for costs (in-
13 cluding reasonable administrative costs) incurred
14 pursuant to this section in providing medical treat-
15 ment under contract to California Indians described
16 in section 809(b) throughout the California contract
17 health services delivery area described in section 218
18 with respect to high-cost contract care cases.

19 "(2) ADMINISTRATION.—Not more than 5 per-
20 cent of the amounts provided to the Board under
21 this section for any fiscal year may be used for reim-
22 bursement for administrative expenses incurred by
23 the Board during such fiscal year.

24 "(3) LIMITATION.—No payment may be made
25 for treatment provided under this section to the ex-

1 tent that payment may be made for such treatment
2 under the Catastrophic Health Emergency Fund de-
3 scribed in section 202 or from amounts appropriated
4 or otherwise made available to the California con-
5 tract health service delivery area for a fiscal year.
6 "(c) ADVISORY BOARD.—There is hereby established
7 an advisory board that shall advise the California Rural
8 Indian Health Board in carrying out this section. The ad-
9 visory board shall be composed of representatives, selected
10 by the California Rural Indian Health Board, from not
11 less than 8 tribal health programs serving California Indi-
12 ans covered under this section, at least 50 percent of
13 whom are not affiliated with the California Rural Indian
14 Health Board.

15 **"SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE**
16 **DELIVERY AREA.**

17 "The State of California, excluding the counties of
18 Alameda, Contra Costa, Los Angeles, Marin, Orange, Sac-
19 ramento, San Francisco, San Mateo, Santa Clara, Kern,
20 Merced, Monterey, Napa, San Benito, San Joaquin, San
21 Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura
22 shall be designated as a contract health service delivery
23 area by the Service for the purpose of providing contract
24 health services to Indians in such State, except that any
25 of the counties described in this section may be included

1 in the contract health services delivery area if funding is
2 specifically provided by the Service for such services in
3 those counties.

4 **"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TREN-**
5 **TON SERVICE AREA.**

6 "(a) IN GENERAL.—The Secretary, acting through
7 the Service, shall provide contract health services to mem-
8 bers of the Turtle Mountain Band of Chippewa Indians
9 that reside in the Trenton Service Area of Divide,
10 McKenzie, and Williams counties in the State of North
11 Dakota and the adjoining counties of Richland, Roosevelt,
12 and Sheridan in the State of Montana.

13 "(b) RULE OF CONSTRUCTION.—Nothing in this sec-
14 tion shall be construed as expanding the eligibility of mem-
15 bers of the Turtle Mountain Band of Chippewa Indians
16 for health services provided by the Service beyond the
17 scope of eligibility for such health services that applied on
18 May 1, 1986.

19 **"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND**
20 **TRIBAL ORGANIZATIONS.**

21 "The Service shall provide funds for health care pro-
22 grams and facilities operated by Indian tribes and tribal
23 organizations under funding agreements with the Service
24 entered into under the Indian Self-Determination and
25 Education Assistance Act on the same basis as such funds

1 are provided to programs and facilities operated directly
2 by the Service.

3 **"SEC. 221. LICENSING.**

4 "Health care professionals employed by Indian Tribes
5 and tribal organizations to carry out agreements under the
6 Indian Self-Determination and Education Assistance Act,
7 shall, if licensed in any State, be exempt from the licensing
8 requirements of the State in which the agreement is per-
9 formed.

10 **"SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT**
11 **HEALTH SERVICES.**

12 "With respect to an elderly Indian or an Indian with
13 a disability receiving emergency medical care or services
14 from a non-Service provider or in a non-Service facility
15 under the authority of this Act, the time limitation (as
16 a condition of payment) for notifying the Service of such
17 treatment or admission shall be 30 days.

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

19 "(a) REQUIREMENT.—The Service shall respond to
20 a notification of a claim by a provider of a contract care
21 service with either an individual purchase order or a denial
22 of the claim within 5 working days after the receipt of
23 such notification.

24 "(b) FAILURE TO RESPOND.—If the Service fails to
25 respond to a notification of a claim in accordance with

1 subsection (a), the Service shall accept as valid the claim
2 submitted by the provider of a contract care service.
3 "(c) PAYMENT.—The Service shall pay a valid con-
4 tract care service claim within 30 days after the comple-
5 tion of the claim.

6 **"SEC. 224. LIABILITY FOR PAYMENT.**

7 "(a) NO LIABILITY.—A patient who receives contract
8 health care services that are authorized by the Service
9 shall not be liable for the payment of any charges or costs
10 associated with the provision of such services.
11 "(b) NOTIFICATION.—The Secretary shall notify a
12 contract care provider and any patient who receives con-
13 tract health care services authorized by the Service that
14 such patient is not liable for the payment of any charges
15 or costs associated with the provision of such services.
16 "(c) LIMITATION.—Following receipt of the notice
17 provided under subsection (b), or, if a claim has been
18 deemed accepted under section 223(b), the provider shall
19 have no further recourse against the patient who received
20 the services involved.

21 **"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.**

22 "There are authorized to be appropriated such sums
23 as may be necessary for each fiscal year through fiscal
24 year 2012 to carry out this title.

"TITLE III—FACILITIES

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

"(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

"(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

"(2) ensure, whenever practicable, that such facility meets the construction standards of any nationally recognized accrediting body by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURE OF FACILITIES.—

"(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by

1 the Service, may be closed if the Secretary has not
2 submitted to the Congress at least 1 year prior to
3 the date such proposed closure an evaluation of the
4 impact of such proposed closure which specifies, in
5 addition to other considerations—
6 "(A) the accessibility of alternative health
7 care resources for the population served by such
8 hospital or facility;
9 "(B) the cost effectiveness of such closure;
10 "(C) the quality of health care to be pro-
11 vided to the population served by such hospital
12 or facility after such closure;
13 "(D) the availability of contract health
14 care funds to maintain existing levels of service;
15 "(E) the views of the Indian tribes served
16 by such hospital or facility concerning such clo-
17 sure;
18 "(F) the level of utilization of such hos-
19 pital or facility by all eligible Indians; and
20 "(G) the distance between such hospital or
21 facility and the nearest operating Service hos-
22 pital.
23 "(2) TEMPORARY CLOSURE.—Paragraph (1)
24 shall not apply to any temporary closure of a facility

1 or of any portion of a facility if such closure is nec-
2 essary for medical, environmental, or safety reasons.
3 "(c) PRIORITY SYSTEM.—
4 "(1) ESTABLISHMENT.—The Secretary shall es-
5 tablish a health care facility priority system, that
6 shall—
7 "(A) be developed with Indian tribes and
8 tribal organizations through negotiated rule-
9 making under section 802;
10 "(B) give the needs of Indian tribes' the
11 highest priority; and
12 "(C) at a minimum, include the lists re-
13 quired in paragraph (2)(B) and the methodol-
14 ogy required in paragraph (2)(E);
15 except that the priority of any project established
16 under the construction priority system in effect on
17 the date of this Act shall not be affected by any
18 change in the construction priority system taking
19 place thereafter if the project was identified as one
20 of the top 10 priority inpatient projects or one of the
21 top 10 outpatient projects in the Indian Health
22 Service budget justification for fiscal year 2000, or
23 if the project had completed both Phase I and Phase
24 II of the construction priority system in effect on
25 the date of this Act.

1 "(2) REPORT.—The Secretary shall submit to
2 the President, for inclusion in each report required
3 to be transmitted to the Congress under section 801,
4 a report that includes—
5 "(A) a description of the health care facil-
6 ity priority system of the Service, as established
7 under paragraph (1);
8 "(B) health care facility lists, including—
9 "(i) the total health care facility plan-
10 ning, design, construction and renovation
11 needs for Indians;
12 "(ii) the 10 top-priority inpatient care
13 facilities;
14 "(iii) the 10 top-priority outpatient
15 care facilities;
16 "(iv) the 10 top-priority specialized
17 care facilities (such as long-term care and
18 alcohol and drug abuse treatment); and
19 "(v) any staff quarters associated
20 with such prioritized facilities;
21 "(C) the justification for the order of pri-
22 ority among facilities;
23 "(D) the projected cost of the projects in-
24 volved; and

1 "(E) the methodology adopted by the Serv-
2 ice in establishing priorities under its health
3 care facility priority system.
4 "(3) CONSULTATION.—In preparing each report
5 required under paragraph (2) (other than the initial
6 report) the Secretary shall annually—
7 "(A) consult with, and obtain information
8 on all health care facilities needs from, Indian
9 tribes and tribal organizations including those
10 tribes or tribal organizations operating health
11 programs or facilities under any funding agree-
12 ment entered into with the Service under the
13 Indian Self-Determination and Education As-
14 sistance Act; and
15 "(B) review the total unmet needs of all
16 tribes and tribal organizations for health care
17 facilities (including staff quarters), including
18 needs for renovation and expansion of existing
19 facilities.
20 "(4) CRITERIA.—For purposes of this sub-
21 section, the Secretary shall, in evaluating the needs
22 of facilities operated under any funding agreement
23 entered into with the Service under the Indian Self-
24 Determination and Education Assistance Act, use
25 the same criteria that the Secretary uses in evaluat-

1 ing the needs of facilities operated directly by the
2 Service.
3 "(5) EQUITABLE INTEGRATION.—The Secretary
4 shall ensure that the planning, design, construction,
5 and renovation needs of Service and non-Service fa-
6 cilities, operated under funding agreements in ac-
7 cordance with the Indian Self-Determination and
8 Education Assistance Act are fully and equitably in-
9 tegrated into the health care facility priority system.
10 "(d) REVIEW OF NEED FOR FACILITIES.—
11 "(1) REPORT.—Beginning in 2001, the Sec-
12 retary shall annually submit to the President, for in-
13 clusion in the report required to be transmitted to
14 Congress under section 801 of this Act, a report
15 which sets forth the needs of the Service and all In-
16 dian tribes and tribal organizations, including urban
17 Indian organizations, for inpatient, outpatient and
18 specialized care facilities, including the needs for
19 renovation and expansion of existing facilities .
20 "(2) CONSULTATION.—In preparing each report
21 required under paragraph (1) (other than the initial
22 report), the Secretary shall consult with Indian
23 tribes and tribal organizations including those tribes
24 or tribal organizations operating health programs or
25 facilities under any funding agreement entered into

1 with the Service under the Indian Self-Determina-
2 tion and Education Assistance Act, and with urban
3 Indian organizations.

4 "(3) CRITERIA.—For purposes of this sub-
5 section, the Secretary shall, in evaluating the needs
6 of facilities operated under any funding agreement
7 entered into with the Service under the Indian Self-
8 Determination and Education Assistance Act, use
9 the same criteria that the Secretary uses in evaluat-
10 ing the needs of facilities operated directly by the
11 Service.

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

19 "(5) ANNUAL NOMINATIONS.—Each year the
20 Secretary shall provide an opportunity for the nomi-
21 nation of planning, design, and construction projects
22 by the Service and all Indian tribes and tribal orga-
23 nizations for consideration under the health care fa-
24 cility priority system.

1 "(e) INCLUSION OF CERTAIN PROGRAMS.—All funds
2 appropriated under the Act of November 2, 1921 (25
3 U.S.C. 13), for the planning, design, construction, or ren-
4 ovation of health facilities for the benefit of an Indian
5 tribe or tribes shall be subject to the provisions of section
6 102 of the Indian Self-Determination and Education As-
7 sistance Act.

8 "(f) INNOVATIVE APPROACHES.—The Secretary shall
9 consult and cooperate with Indian tribes, tribal organiza-
10 tions and urban Indian organizations in developing inno-
11 vative approaches to address all or part of the total unmet
12 need for construction of health facilities, including those
13 provided for in other sections of this title and other ap-
14 proaches.

15 **"SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL**
16 **FACILITIES.**

17 "(a) FINDINGS.—Congress finds and declares that—
18 "(1) the provision of safe water supply facilities
19 and sanitary sewage and solid waste disposal facili-
20 ties is primarily a health consideration and function;
21 "(2) Indian people suffer an inordinately high
22 incidence of disease, injury, and illness directly at-
23 tributable to the absence or inadequacy of such fa-
24 cilities;

1 "(3) the long-term cost to the United States of
2 treating and curing such disease, injury, and illness
3 is substantially greater than the short-term cost of
4 providing such facilities and other preventive health
5 measures;
6 "(4) many Indian homes and communities still
7 lack safe water supply facilities and sanitary sewage
8 and solid waste disposal facilities; and
9 "(5) it is in the interest of the United States,
10 and it is the policy of the United States, that all In-
11 dian communities and Indian homes, new and exist-
12 ing, be provided with safe and adequate water sup-
13 ply facilities and sanitary sewage waste disposal fa-
14 cilities as soon as possible.
15 "(b) PROVISION OF FACILITIES AND SERVICES.—
16 "(1) IN GENERAL.—In furtherance of the find-
17 ings and declarations made in subsection (a), Con-
18 gress reaffirms the primary responsibility and au-
19 thority of the Service to provide the necessary sani-
20 tation facilities and services as provided in section 7
21 of the Act of August 5, 1954 (42 U.S.C. 2004a).
22 "(2) ASSISTANCE.—The Secretary, acting
23 through the Service, is authorized to provide under
24 section 7 of the Act of August 5, 1954 (42 U.S.C.
25 2004a)—

1 "(A) financial and technical assistance to
2 Indian tribes, tribal organizations and Indian
3 communities in the establishment, training, and
4 equipping of utility organizations to operate
5 and maintain Indian sanitation facilities, in-
6 cluding the provision of existing plans, standard
7 details, and specifications available in the De-
8 partment, to be used at the option of the tribe
9 or tribal organization;
10 "(B) ongoing technical assistance and
11 training in the management of utility organiza-
12 tions which operate and maintain sanitation fa-
13 cilities; and
14 "(C) priority funding for the operation,
15 and maintenance assistance for, and emergency
16 repairs to, tribal sanitation facilities when nec-
17 essary to avoid an imminent health threat or to
18 protect the investment in sanitation facilities
19 and the investment in the health benefits
20 gained through the provision of sanitation fa-
21 cilities.
22 "(3) PROVISIONS RELATING TO FUNDING.—
23 Notwithstanding any other provision of law—
24 "(A) the Secretary of Housing and Urban
25 Development is authorized to transfer funds ap-

1 propriated under the Native American Housing
2 Assistance and Self-Determination Act of 1996
3 to the Secretary of Health and Human Serv-
4 ices;
5 "(B) the Secretary of Health and Human
6 Services is authorized to accept and use such
7 funds for the purpose of providing sanitation
8 facilities and services for Indians under section
9 7 of the Act of August 5, 1954 (42 U.S.C.
10 2004a);
11 "(C) unless specifically authorized when
12 funds are appropriated, the Secretary of Health
13 and Human Services shall not use funds appro-
14 priated under section 7 of the Act of August 5,
15 1954 (42 U.S.C. 2004a) to provide sanitation
16 facilities to new homes constructed using funds
17 provided by the Department of Housing and
18 Urban Development;
19 "(D) the Secretary of Health and Human
20 Services is authorized to accept all Federal
21 funds that are available for the purpose of pro-
22 viding sanitation facilities and related services
23 and place those funds into funding agreements,
24 authorized under the Indian Self-Determination
25 and Education Assistance Act, between the Sec-

1 retary and Indian tribes and tribal organiza-
2 tions;
3 "(E) the Secretary may permit funds ap-
4 propriated under the authority of section 4 of
5 the Act of August 5, 1954 (42 U.S.C. 2004) to
6 be used to fund up to 100 percent of the
7 amount of a tribe's loan obtained under any
8 Federal program for new projects to construct
9 eligible sanitation facilities to serve Indian
10 homes;
11 "(F) the Secretary may permit funds ap-
12 propriated under the authority of section 4 of
13 the Act of August 5, 1954 (42 U.S.C. 2004) to
14 be used to meet matching or cost participation
15 requirements under other Federal and non-Fed-
16 eral programs for new projects to construct eli-
17 gible sanitation facilities;
18 "(G) all Federal agencies are authorized to
19 transfer to the Secretary funds identified,
20 granted, loaned or appropriated and thereafter
21 the Department's applicable policies, rules, reg-
22 ulations shall apply in the implementation of
23 such projects;
24 "(H) the Secretary of Health and Human
25 Services shall enter into inter-agency agree-

1 ments with the Bureau of Indian Affairs, the
2 Department of Housing and Urban Develop-
3 ment, the Department of Agriculture, the Envi-
4 ronmental Protection Agency and other appro-
5 priate Federal agencies, for the purpose of pro-
6 viding financial assistance for safe water supply
7 and sanitary sewage disposal facilities under
8 this Act; and
9 "(I) the Secretary of Health and Human
10 Services shall, by regulation developed through
11 rulemaking under section 802, establish stand-
12 ards applicable to the planning, design and con-
13 struction of water supply and sanitary sewage
14 and solid waste disposal facilities funded under
15 this Act.
16 "(c) 10-YEAR FUNDING PLAN.—The Secretary, act-
17 ing through the Service and in consultation with Indian
18 tribes and tribal organizations, shall develop and imple-
19 ment a 10-year funding plan to provide safe water supply
20 and sanitary sewage and solid waste disposal facilities
21 serving existing Indian homes and communities, and to
22 new and renovated Indian homes.
23 "(d) CAPABILITY OF TRIBE OR COMMUNITY.—The
24 financial and technical capability of an Indian tribe or
25 community to safely operate and maintain a sanitation fa-

1 cility shall not be a prerequisite to the provision or con-
2 struction of sanitation facilities by the Secretary.
3 "(e) FINANCIAL ASSISTANCE.—The Secretary may
4 provide financial assistance to Indian tribes, tribal organi-
5 zations and communities for the operation, management,
6 and maintenance of their sanitation facilities.
7 "(f) RESPONSIBILITY FOR FEES FOR OPERATION
8 AND MAINTENANCE.—The Indian family, community or
9 tribe involved shall have the primary responsibility to es-
10 tablish, collect, and use reasonable user fees, or otherwise
11 set aside funding, for the purpose of operating and main-
12 taining sanitation facilities. If a community facility is
13 threatened with imminent failure and there is a lack of
14 tribal capacity to maintain the integrity or the health ben-
15 efit of the facility, the Secretary may assist the Tribe in
16 the resolution of the problem on a short term basis
17 through cooperation with the emergency coordinator or by
18 providing operation and maintenance service.
19 "(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANI-
20 ZATIONS.—Programs administered by Indian tribes or
21 tribal organizations under the authority of the Indian Self-
22 Determination and Education Assistance Act shall be eli-
23 gible for—
24 "(1) any funds appropriated pursuant to this
25 section; and

1 "(2) any funds appropriated for the purpose of
2 providing water supply, sewage disposal, or solid
3 waste facilities;
4 on an equal basis with programs that are administered
5 directly by the Service.
6 "(h) REPORT.—
7 "(1) IN GENERAL.—The Secretary shall submit
8 to the President, for inclusion in each report re-
9 quired to be transmitted to the Congress under sec-
10 tion 801, a report which sets forth—
11 "(A) the current Indian sanitation facility
12 priority system of the Service;
13 "(B) the methodology for determining
14 sanitation deficiencies;
15 "(C) the level of initial and final sanitation
16 deficiency for each type sanitation facility for
17 each project of each Indian tribe or community;
18 and
19 "(D) the amount of funds necessary to re-
20 duce the identified sanitation deficiency levels of
21 all Indian tribes and communities to a level I
22 sanitation deficiency as described in paragraph
23 (4)(A).
24 "(2) CONSULTATION.—In preparing each report
25 required under paragraph (1), the Secretary shall

1 consult with Indian tribes and tribal organizations
2 (including those tribes or tribal organizations operat-
3 ing health care programs or facilities under any
4 funding agreements entered into with the Service
5 under the Indian Self-Determination and Education
6 Assistance Act) to determine the sanitation needs of
7 each tribe and in developing the criteria on which
8 the needs will be evaluated through a process of ne-
9 gotiated rulemaking.

10 "(3) METHODOLOGY.—The methodology used
11 by the Secretary in determining, preparing cost esti-
12 mates for and reporting sanitation deficiencies for
13 purposes of paragraph (1) shall be applied uniformly
14 to all Indian tribes and communities.

15 "(4) SANITATION DEFICIENCY LEVELS.—For
16 purposes of this subsection, the sanitation deficiency
17 levels for an individual or community sanitation fa-
18 cility serving Indian homes are as follows:

19 "(A) A level I deficiency is a sanitation fa-
20 cility serving and individual or community—

21 "(i) which complies with all applicable
22 water supply, pollution control and solid
23 waste disposal laws; and

1 "(ii) in which the deficiencies relate to
2 routine replacement, repair, or mainte-
3 nance needs.
4 "(B) A level II deficiency is a sanitation
5 facility serving and individual or community—
6 "(i) which substantially or recently
7 complied with all applicable water supply,
8 pollution control and solid waste laws, in
9 which the deficiencies relate to small or
10 minor capital improvements needed to
11 bring the facility back into compliance;
12 "(ii) in which the deficiencies relate to
13 capital improvements that are necessary to
14 enlarge or improve the facilities in order to
15 meet the current needs for domestic sani-
16 tation facilities; or
17 "(iii) in which the deficiencies relate
18 to the lack of equipment or training by an
19 Indian Tribe or community to properly op-
20 erate and maintain the sanitation facilities.
21 "(C) A level III deficiency is an individual
22 or community facility with water or sewer serv-
23 ice in the home, piped services or a haul system
24 with holding tanks and interior plumbing, or
25 where major significant interruptions to water

1 supply or sewage disposal occur frequently, re-
2 quiring major capital improvements to correct
3 the deficiencies. There is no access to or no ap-
4 proved or permitted solid waste facility avail-
5 able.

6 "(D) A level IV deficiency is an individual
7 or community facility where there are no piped
8 water or sewer facilities in the home or the fa-
9 cility has become inoperable due to major com-
10 ponent failure or where only a washeteria or
11 central facility exists.

12 "(E) A level V deficiency is the absence of
13 a sanitation facility, where individual homes do
14 not have access to safe drinking water or ade-
15 quate wastewater disposal.

16 "(i) DEFINITIONS.—In this section:

17 "(1) FACILITY.—The terms 'facility' or 'facili-
18 ties' shall have the same meaning as the terms 'sys-
19 tem' or 'systems' unless the context requires other-
20 wise.

21 "(2) INDIAN COMMUNITY.—The term 'Indian
22 community' means a geographic area, a significant
23 proportion of whose inhabitants are Indians and
24 which is served by or capable of being served by a
25 facility described in this section.

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

2 "(a) IN GENERAL.—The Secretary, acting through
3 the Service, may utilize the negotiating authority of the
4 Act of June 25, 1910 (25 U.S.C. 47), to give preference
5 to any Indian or any enterprise, partnership, corporation,
6 or other type of business organization owned and con-
7 trolled by an Indian or Indians including former or cur-
8 rently federally recognized Indian tribes in the State of
9 New York (hereinafter referred to as an 'Indian firm') in
10 the construction and renovation of Service facilities pursu-
11 ant to section 301 and in the construction of safe water
12 and sanitary waste disposal facilities pursuant to section
13 302. Such preference may be accorded by the Secretary
14 unless the Secretary finds, pursuant to rules and regula-
15 tions promulgated by the Secretary, that the project or
16 function to be contracted for will not be satisfactory or
17 such project or function cannot be properly completed or
18 maintained under the proposed contract. The Secretary,
19 in arriving at such finding, shall consider whether the In-
20 dian or Indian firm will be deficient with respect to—

21 "(1) ownership and control by Indians;

22 "(2) equipment;

23 "(3) bookkeeping and accounting procedures;

24 "(4) substantive knowledge of the project or
25 function to be contracted for;

26 "(5) adequately trained personnel; or

1 "(6) other necessary components of contract
2 performance.
3 "(b) EXEMPTION FROM DAVIS-BACON.—For the
4 purpose of implementing the provisions of this title, con-
5 struction or renovation of facilities constructed or ren-
6 ovated in whole or in part by funds made available pursu-
7 ant to this title are exempt from the Act of March 3, 1931
8 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon
9 Act). For all health facilities, staff quarters and sanitation
10 facilities, construction and renovation subcontractors shall
11 be paid wages at rates that are not less than the prevailing
12 wage rates for similar construction in the locality involved,
13 as determined by the Indian tribe, Tribes, or tribal organi-
14 zations served by such facilities.

15 **"SEC. 304. SOBOBA SANITATION FACILITIES.**

16 "Nothing in the Act of December 17, 1970 (84 Stat.
17 1465) shall be construed to preclude the Soboba Band of
18 Mission Indians and the Soboba Indian Reservation from
19 being provided with sanitation facilities and services under
20 the authority of section 7 of the Act of August 5, 1954
21 (68 Stat 674), as amended by the Act of July 31, 1959
22 (73 Stat. 267).

23 **"SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR REN-**
24 **OVATION.**

25 "(a) PERMISSIBILITY.—

1 "(1) IN GENERAL.—Notwithstanding any other
2 provision of law, the Secretary is authorized to ac-
3 cept any major expansion, renovation or moderniza-
4 tion by any Indian tribe of any Service facility, or
5 of any other Indian health facility operated pursuant
6 to a funding agreement entered into under the In-
7 dian Self-Determination and Education Assistance
8 Act, including—
9 "(A) any plans or designs for such expan-
10 sion, renovation or modernization; and
11 "(B) any expansion, renovation or mod-
12 ernization for which funds appropriated under
13 any Federal law were lawfully expended;
14 but only if the requirements of subsection (b) are
15 met.
16 "(2) PRIORITY LIST.—The Secretary shall
17 maintain a separate priority list to address the need
18 for increased operating expenses, personnel or equip-
19 ment for such facilities described in paragraph (1).
20 The methodology for establishing priorities shall be
21 developed by negotiated rulemaking under section
22 802. The list of priority facilities will be revised an-
23 nually in consultation with Indian tribes and tribal
24 organizations.

1 "(3) REPORT.—The Secretary shall submit to
2 the President, for inclusion in each report required
3 to be transmitted to the Congress under section 801,
4 the priority list maintained pursuant to paragraph
5 (2).
6 "(b) REQUIREMENTS.—The requirements of this sub-
7 section are met with respect to any expansion, renovation
8 or modernization if—
9 "(1) the tribe or tribal organization—
10 "(A) provides notice to the Secretary of its
11 intent to expand, renovate or modernize; and
12 "(B) applies to the Secretary to be placed
13 on a separate priority list to address the needs
14 of such new facilities for increased operating ex-
15 penses, personnel or equipment; and
16 "(2) the expansion renovation or
17 modernization—
18 "(A) is approved by the appropriate area
19 director of the Service for Federal facilities; and
20 "(B) is administered by the Indian tribe or
21 tribal organization in accordance with any ap-
22 plicable regulations prescribed by the Secretary
23 with respect to construction or renovation of
24 Service facilities.

1 "(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FA-
2 CILITY TO BE USED AS A SERVICE FACILITY.—If any
3 Service facility which has been expanded, renovated or
4 modernized by an Indian tribe under this section ceases
5 to be used as a Service facility during the 20-year period
6 beginning on the date such expansion, renovation or mod-
7 ernization is completed, such Indian tribe shall be entitled
8 to recover from the United States an amount which bears
9 the same ratio to the value of such facility at the time
10 of such cessation as the value of such expansion, renova-
11 tion or modernization (less the total amount of any funds
12 provided specifically for such facility under any Federal
13 program that were expended for such expansion, renova-
14 tion or modernization) bore to the value of such facility
15 at the time of the completion of such expansion, renova-
16 tion or modernization.

17 **"SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION,**
18 **AND MODERNIZATION OF SMALL AMBULA-**
19 **TORY CARE FACILITIES.**

20 "(a) AVAILABILITY OF FUNDING.—

21 "(1) IN GENERAL.—The Secretary, acting
22 through the Service and in consultation with Indian
23 tribes and tribal organization, shall make funding
24 available to tribes and tribal organizations for the
25 construction, expansion, or modernization of facili-

1 ties for the provision of ambulatory care services to
2 eligible Indians (and noneligible persons as provided
3 for in subsections (b)(2) and (c)(1)(C)). Funding
4 under this section may cover up to 100 percent of
5 the costs of such construction, expansion, or mod-
6 ernization. For the purposes of this section, the term
7 'construction' includes the replacement of an exist-
8 ing facility.

9 "(2) REQUIREMENT.—Funding under para-
10 graph (1) may only be made available to an Indian
11 tribe or tribal organization operating an Indian
12 health facility (other than a facility owned or con-
13 structed by the Service, including a facility originally
14 owned or constructed by the Service and transferred
15 to an Indian tribe or tribal organization) pursuant
16 to a funding agreement entered into under the In-
17 dian Self-Determination and Education Assistance
18 Act.

19 "(b) USE OF FUNDS.—

20 "(1) IN GENERAL.—Funds provided under this
21 section may be used only for the construction, ex-
22 pansion, or modernization (including the planning
23 and design of such construction, expansion, or mod-
24 ernization) of an ambulatory care facility—

25 "(A) located apart from a hospital;

1 "(B) not funded under section 301 or sec-
2 tion 307; and
3 "(C) which, upon completion of such con-
4 struction, expansion, or modernization will—
5 "(i) have a total capacity appropriate
6 to its projected service population;
7 "(ii) provide annually not less than
8 500 patient visits by eligible Indians and
9 other users who are eligible for services in
10 such facility in accordance with section
11 807(b)(1)(B); and
12 "(iii) provide ambulatory care in a
13 service area (specified in the funding
14 agreement entered into under the Indian
15 Self-Determination and Education Assist-
16 ance Act) with a population of not less
17 than 1,500 eligible Indians and other users
18 who are eligible for services in such facility
19 in accordance with section 807(b)(1)(B).
20 "(2) LIMITATION.—Funding provided under
21 this section may be used only for the cost of that
22 portion of a construction, expansion or moderniza-
23 tion project that benefits the service population de-
24 scribed in clauses (ii) and (iii) of paragraph (1)(C).
25 The requirements of such clauses (ii) and (iii) shall

1 not apply to a tribe or tribal organization applying
2 for funding under this section whose principal office
3 for health care administration is located on an island
4 or where such office is not located on a road system
5 providing direct access to an inpatient hospital
6 where care is available to the service population.
7 "(c) APPLICATION AND PRIORITY.—
8 "(1) APPLICATION.—No funding may be made
9 available under this section unless an application for
10 such funding has been submitted to and approved by
11 the Secretary. An application or proposal for fund-
12 ing under this section shall be submitted in accord-
13 ance with applicable regulations and shall set forth
14 reasonable assurance by the applicant that, at all
15 times after the construction, expansion, or mod-
16 ernization of a facility carried out pursuant to fund-
17 ing received under this section—
18 "(A) adequate financial support will be
19 available for the provision of services at such
20 facility;
21 "(B) such facility will be available to eligi-
22 ble Indians without regard to ability to pay or
23 source of payment; and
24 "(C) such facility will, as feasible without
25 diminishing the quality or quantity of services

1 provided to eligible Indians, serve noneligible
2 persons on a cost basis.
3 "(2) PRIORITY.—In awarding funds under this
4 section, the Secretary shall give priority to tribes
5 and tribal organizations that demonstrate—
6 "A) a need for increased ambulatory care
7 services; and
8 "(B) insufficient capacity to deliver such
9 services.
10 "(d) FAILURE TO USE FACILITY AS HEALTH FACIL-
11 ITY.—If any facility (or portion thereof) with respect to
12 which funds have been paid under this section, ceases,
13 within 5 years after completion of the construction, expan-
14 sion, or modernization carried out with such funds, to be
15 utilized for the purposes of providing health care services
16 to eligible Indians, all of the right, title, and interest in
17 and to such facility (or portion thereof) shall transfer to
18 the United States unless otherwise negotiated by the Serv-
19 ice and the Indian tribe or tribal organization.
20 "(e) NO INCLUSION IN TRIBAL SHARE.—Funding
21 provided to Indian tribes and tribal organizations under
22 this section shall be non-recurring and shall not be avail-
23 able for inclusion in any individual tribe's tribal share for
24 an award under the Indian Self-Determination and Edu-

1 cation Assistance Act or for reallocation or redesign there-
2 under.

3 **"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRA-**
4 **TION PROJECT.**

5 "(a) HEALTH CARE DELIVERY DEMONSTRATION
6 PROJECTS.—The Secretary, acting through the Service
7 and in consultation with Indian tribes and tribal organiza-
8 tions, may enter into funding agreements with, or make
9 grants or loan guarantees to, Indian tribes or tribal orga-
10 nizations for the purpose of carrying out a health care de-
11 livery demonstration project to test alternative means of
12 delivering health care and services through health facili-
13 ties, including hospice, traditional Indian health and child
14 care facilities, to Indians.

15 "(b) USE OF FUNDS.—The Secretary, in approving
16 projects pursuant to this section, may authorize funding
17 for the construction and renovation of hospitals, health
18 centers, health stations, and other facilities to deliver
19 health care services and is authorized to—

20 "(1) waive any leasing prohibition;

21 "(2) permit carryover of funds appropriated for
22 the provision of health care services;

23 "(3) permit the use of other available funds;

24 "(4) permit the use of funds or property do-
25 nated from any source for project purposes;

1 "(5) provide for the reversion of donated real or
2 personal property to the donor; and
3 "(6) permit the use of Service funds to match
4 other funds, including Federal funds.
5 "(c) CRITERIA.—
6 "(1) IN GENERAL.—The Secretary shall develop
7 and publish regulations through rulemaking under
8 section 802 for the review and approval of applica-
9 tions submitted under this section. The Secretary
10 may enter into a contract, funding agreement or
11 award a grant under this section for projects which
12 meet the following criteria:
13 "(A) There is a need for a new facility or
14 program or the reorientation of an existing fa-
15 cility or program.
16 "(B) A significant number of Indians, in-
17 cluding those with low health status, will be
18 served by the project.
19 "(C) The project has the potential to ad-
20 dress the health needs of Indians in an innova-
21 tive manner.
22 "(D) The project has the potential to de-
23 liver services in an efficient and effective man-
24 ner.
25 "(E) The project is economically viable.

1 "(F) The Indian tribe or tribal organization has
2 the administrative and financial capability to admin-
3 ister the project.
4 "(G) The project is integrated with provid-
5 ers of related health and social services and is
6 coordinated with, and avoids duplication of, ex-
7 isting services.
8 "(2) PEER REVIEW PANELS.—The Secretary
9 may provide for the establishment of peer review
10 panels, as necessary, to review and evaluate applica-
11 tions and to advise the Secretary regarding such ap-
12 plications using the criteria developed pursuant to
13 paragraph (1).
14 "(3) PRIORITY.—The Secretary shall give prior-
15 ity to applications for demonstration projects under
16 this section in each of the following service units to
17 the extent that such applications are filed in a time-
18 ly manner and otherwise meet the criteria specified
19 in paragraph (1):
20 "(A) Cass Lake, Minnesota.
21 "(B) Clinton, Oklahoma.
22 "(C) Harlem, Montana.
23 "(D) Mescalero, New Mexico.
24 "(E) Owyhee, Nevada.
25 "(F) Parker, Arizona.

1 "(G) Schurz, Nevada.

2 "(H) Winnebago, Nebraska.

3 "(I) Ft. Yuma, California

4 "(d) TECHNICAL ASSISTANCE.—The Secretary shall
5 provide such technical and other assistance as may be nec-
6 essary to enable applicants to comply with the provisions
7 of this section.

8 "(e) SERVICE TO INELIGIBLE PERSONS.—The au-
9 thority to provide services to persons otherwise ineligible
10 for the health care benefits of the Service and the author-
11 ity to extend hospital privileges in Service facilities to non-
12 Service health care practitioners as provided in section
13 807 may be included, subject to the terms of such section,
14 in any demonstration project approved pursuant to this
15 section.

16 "(f) EQUITABLE TREATMENT.—For purposes of sub-
17 section (c)(1)(A), the Secretary shall, in evaluating facili-
18 ties operated under any funding agreement entered into
19 with the Service under the Indian Self-Determination and
20 Education Assistance Act, use the same criteria that the
21 Secretary uses in evaluating facilities operated directly by
22 the Service.

23 "(g) EQUITABLE INTEGRATION OF FACILITIES.—
24 The Secretary shall ensure that the planning, design, con-
25 struction, renovation and expansion needs of Service and

1 non-Service facilities which are the subject of a funding
2 agreement for health services entered into with the Service
3 under the Indian Self-Determination and Education As-
4 sistance Act, are fully and equitably integrated into the
5 implementation of the health care delivery demonstration
6 projects under this section.

7 **"SEC. 308. LAND TRANSFER.**

8 "(a) GENERAL AUTHORITY FOR TRANSFERS.—Not-
9 withstanding any other provision of law, the Bureau of
10 Indian Affairs and all other agencies and departments of
11 the United States are authorized to transfer, at no cost,
12 land and improvements to the Service for the provision
13 of health care services. The Secretary is authorized to ac-
14 cept such land and improvements for such purposes.

15 "(b) CHEMAWA INDIAN SCHOOL.—The Bureau of In-
16 dian Affairs is authorized to transfer, at no cost, up to
17 5 acres of land at the Chemawa Indian School, Salem,
18 Oregon, to the Service for the provision of health care
19 services. The land authorized to be transferred by this sec-
20 tion is that land adjacent to land under the jurisdiction
21 of the Service and occupied by the Chemawa Indian
22 Health Center.

23 **"SEC. 309. LEASES.**

24 "(a) IN GENERAL.—Notwithstanding any other pro-
25 vision of law, the Secretary is authorized, in carrying out

1 the purposes of this Act, to enter into leases with Indian
2 tribes and tribal organizations for periods not in excess
3 of 20 years. Property leased by the Secretary from an In-
4 dian tribe or tribal organization may be reconstructed or
5 renovated by the Secretary pursuant to an agreement with
6 such Indian tribe or tribal organization.

7 "(b) FACILITIES FOR THE ADMINISTRATION AND DE-
8 LIVERY OF HEALTH SERVICES.—The Secretary may enter
9 into leases, contracts, and other legal agreements with In-
10 dian tribes or tribal organizations which hold—

11 "(1) title to;

12 "(2) a leasehold interest in; or

13 "(3) a beneficial interest in (where title is held
14 by the United States in trust for the benefit of a
15 tribe);

16 facilities used for the administration and delivery of health
17 services by the Service or by programs operated by Indian
18 tribes or tribal organizations to compensate such Indian
19 tribes or tribal organizations for costs associated with the
20 use of such facilities for such purposes, and such leases
21 shall be considered as operating leases for the purposes
22 of scoring under the Budget Enforcement Act, notwith-
23 standing any other provision of law. Such costs include
24 rent, depreciation based on the useful life of the building,
25 principal and interest paid or accrued, operation and

1 maintenance expenses, and other expenses determined by
2 regulation to be allowable pursuant to regulations under
3 section 105(l) of the Indian Self-Determination and Edu-
4 cation Assistance Act.

5 **"SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAY-**
6 **MENT.**

7 "(a) HEALTH CARE FACILITIES LOAN FUND.—
8 There is established in the Treasury of the United States
9 a fund to be known as the 'Health Care Facilities Loan
10 Fund' (referred to in this Act as the 'HCFLF') to provide
11 to Indian Tribes and tribal organizations direct loans, or
12 guarantees for loans, for the construction of health care
13 facilities (including inpatient facilities, outpatient facili-
14 ties, associated staff quarters and specialized care facili-
15 ties such as behavioral health and elder care facilities).

16 "(b) STANDARDS AND PROCEDURES.—The Secretary
17 may promulgate regulations, developed through rule-
18 making as provided for in section 802, to establish stand-
19 ards and procedures for governing loans and loan guaran-
20 tees under this section, subject to the following conditions:

21 "(1) The principal amount of a loan or loan
22 guarantee may cover up to 100 percent of eligible
23 costs, including costs for the planning, design, fi-
24 nancing, site land development, construction, reha-
25 bilitation, renovation, conversion, improvements,

1 medical equipment and furnishings, other facility re-
2 lated costs and capital purchase (but excluding staff-
3 ing).

4 "(2) The cumulative total of the principal of di-
5 rect loans and loan guarantees, respectively, out-
6 standing at any one time shall not exceed such limi-
7 tations as may be specified in appropriation Acts.

8 "(3) In the discretion of the Secretary, the pro-
9 gram under this section may be administered by the
10 Service or the Health Resources and Services Ad-
11 ministration (which shall be specified by regulation).

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

15 "(5) The Secretary may allocate up to 100 per-
16 cent of the funds available for loans or loan guaran-
17 tees in any year for the purpose of planning and ap-
18 plying for a loan or loan guarantee.

19 "(6) The Secretary may accept an assignment
20 of the revenue of an Indian tribe or tribal organiza-
21 tion as security for any direct loan or loan guarantee
22 under this section.

23 "(7) In the planning and design of health facili-
24 ties under this section, users eligible under section

1 807(b) may be included in any projection of patient
2 population.
3 "(8) The Secretary shall not collect loan appli-
4 cation, processing or other similar fees from Indian
5 tribes or tribal organizations applying for direct
6 loans or loan guarantees under this section.
7 "(9) Service funds authorized under loans or
8 loan guarantees under this section may be used in
9 matching other Federal funds.
10 "(c) FUNDING.—
11 "(1) IN GENERAL.—The HCFLF shall consist
12 of—
13 "(A) such sums as may be initially appro-
14 priated to the HCFLF and as may be subse-
15 quently appropriated under paragraph (2);
16 "(B) such amounts as may be collected
17 from borrowers; and
18 "(C) all interest earned on amounts in the
19 HCFLF.
20 "(2) AUTHORIZATION OF APPROPRIATIONS.—
21 There is authorized to be appropriated such sums as
22 may be necessary to initiate the HCFLF. For each
23 fiscal year after the initial year in which funds are
24 appropriated to the HCFLF, there is authorized to
25 be appropriated an amount equal to the sum of the

1 amount collected by the HCFLF during the preced-
2 ing fiscal year, and all accrued interest on such
3 amounts.

4 "(3) AVAILABILITY OF FUNDS.—Amounts ap-
5 propriated, collected or earned relative to the
6 HCFLF shall remain available until expended.

7 "(d) FUNDING AGREEMENTS.—Amounts in the
8 HCFLF and available pursuant to appropriation Acts may
9 be expended by the Secretary, acting through the Service,
10 to make loans under this section to an Indian tribe or trib-
11 al organization pursuant to a funding agreement entered
12 into under the Indian Self-Determination and Education
13 Assistance Act.

14 "(e) INVESTMENTS.—The Secretary of the Treasury
15 shall invest such amounts of the HCFLF as such Sec-
16 retary determines are not required to meet current with-
17 drawals from the HCFLF. Such investments may be made
18 only in interest-bearing obligations of the United States.
19 For such purpose, such obligations may be acquired on
20 original issue at the issue price, or by purchase of out-
21 standing obligations at the market price. Any obligation
22 acquired by the fund may be sold by the Secretary of the
23 Treasury at the market price.

24 "(f) GRANTS.—The Secretary is authorized to estab-
25 lish a program to provide grants to Indian tribes and trib-

1 al organizations for the purpose of repaying all or part
2 of any loan obtained by an Indian tribe or tribal organiza-
3 tion for construction and renovation of health care facili-
4 ties (including inpatient facilities, outpatient facilities, as-
5 sociated staff quarters and specialized care facilities).
6 Loans eligible for such repayment grants shall include
7 loans that have been obtained under this section or other-
8 wise.

9 **"SEC. 311. TRIBAL LEASING.**

10 "Indian Tribes and tribal organizations providing
11 health care services pursuant to a funding agreement con-
12 tract entered into under the Indian Self-Determination
13 and Education Assistance Act may lease permanent struc-
14 tures for the purpose of providing such health care serv-
15 ices without obtaining advance approval in appropriation
16 Acts.

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

19 "(a) AUTHORITY.—

20 "(1) IN GENERAL.—The Secretary, acting
21 through the Service, shall make arrangements with
22 Indian tribes and tribal organizations to establish
23 joint venture demonstration projects under which an
24 Indian tribe or tribal organization shall expend trib-
25 al, private, or other available funds, for the acquisi-

1 tion or construction of a health facility for a mini-
2 mum of 10 years, under a no-cost lease, in exchange
3 for agreement by the Service to provide the equip-
4 ment, supplies, and staffing for the operation and
5 maintenance of such a health facility.

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

10 "(3) ELIGIBILITY OF CERTAIN ENTITIES.—A
11 tribe that has begun and substantially completed the
12 process of acquisition or construction of a health fa-
13 cility shall be eligible to establish a joint venture
14 project with the Service using such health facility.

15 "(b) REQUIREMENTS.—

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

19 "(A) the Secretary first determines that
20 the Indian tribe or tribal organization has the
21 administrative and financial capabilities nec-
22 essary to complete the timely acquisition or con-
23 struction of the health facility described in sub-
24 section (a)(1); and

1 "(B) the Indian tribe or tribal organization
2 meets the needs criteria that shall be developed
3 through the negotiated rulemaking process pro-
4 vided for under section 802.
5 "(2) CONTINUED OPERATION OF FACILITY.—
6 The Secretary shall negotiate an agreement with the
7 Indian tribe or tribal organization regarding the con-
8 tinued operation of a facility under this section at
9 the end of the initial 10 year no-cost lease period.
10 "(3) BREACH OR TERMINATION OF AGREE-
11 MENT.—An Indian tribe or tribal organization that
12 has entered into a written agreement with the Sec-
13 retary under this section, and that breaches or ter-
14 minates without cause such agreement, shall be lia-
15 ble to the United States for the amount that has
16 been paid to the tribe or tribal organization, or paid
17 to a third party on the tribe's or tribal organiza-
18 tion's behalf, under the agreement. The Secretary
19 has the right to recover tangible property (including
20 supplies), and equipment, less depreciation, and any
21 funds expended for operations and maintenance
22 under this section. The preceding sentence shall not
23 apply to any funds expended for the delivery of
24 health care services, or for personnel or staffing.

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

8 "(e) DEFINITION.—In this section, the terms 'health
9 facility' or 'health facilities' include staff quarters needed
10 to provide housing for the staff of the tribal health pro-
11 gram.

12 **"SEC. 313. LOCATION OF FACILITIES.**

13 "(a) PRIORITY.—The Bureau of Indian Affairs and
14 the Service shall, in all matters involving the reorganiza-
15 tion or development of Service facilities, or in the estab-
16 lishment of related employment projects to address unem-
17 ployment conditions in economically depressed areas, give
18 priority to locating such facilities and projects on Indian
19 lands if requested by the Indian owner and the Indian
20 tribe with jurisdiction over such lands or other lands
21 owned or leased by the Indian tribe or tribal organization
22 so long as priority is given to Indian land owned by an
23 Indian tribe or tribes.

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

1 "(1) all lands within the exterior boundaries of
2 any Indian reservation;
3 "(2) any lands title to which is held in trust by
4 the United States for the benefit of any Indian tribe
5 or individual Indian, or held by any Indian tribe or
6 individual Indian subject to restriction by the United
7 States against alienation and over which an Indian
8 tribe exercises governmental power; and
9 "(3) all lands in Alaska owned by any Alaska
10 Native village, or any village or regional corporation
11 under the Alaska Native Claims Settlement Act, or
12 any land allotted to any Alaska Native.

13 **"SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH**
14 **CARE FACILITIES.**

15 "(a) REPORT.—The Secretary shall submit to the
16 President, for inclusion in the report required to be trans-
17 mitted to Congress under section 801, a report that identi-
18 fies the backlog of maintenance and repair work required
19 at both Service and tribal facilities, including new facilities
20 expected to be in operation in the fiscal year after the year
21 for which the report is being prepared. The report shall
22 identify the need for renovation and expansion of existing
23 facilities to support the growth of health care programs.
24 "(b) MAINTENANCE OF NEWLY CONSTRUCTED
25 SPACE.—

1 "(1) IN GENERAL.—The Secretary may expend
2 maintenance and improvement funds to support the
3 maintenance of newly constructed space only if such
4 space falls within the approved supportable space al-
5 location for the Indian tribe or tribal organization.
6 "(2) DEFINITION.—For purposes of paragraph
7 (1), the term 'supportable space allocation' shall be
8 defined through the negotiated rulemaking process
9 provided for under section 802.
10 "(c) CONSTRUCTION OF REPLACEMENT FACILI-
11 TIES.—
12 "(1) IN GENERAL.—In addition to using main-
13 tenance and improvement funds for the maintenance
14 of facilities under subsection (b)(1), an Indian tribe
15 or tribal organization may use such funds for the
16 construction of a replacement facility if the costs of
17 the renovation of such facility would exceed a maxi-
18 mum renovation cost threshold.
19 "(2) DEFINITION.—For purposes of paragraph
20 (1), the term 'maximum renovation cost threshold'
21 shall be defined through the negotiated rulemaking
22 process provided for under section 802.
23 **"SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED**
24 **QUARTERS.**
25 "(a) ESTABLISHMENT OF RENTAL RATES.—

1 "(1) IN GENERAL.—Notwithstanding any other
2 provision of law, an Indian tribe or tribal organiza-
3 tion which operates a hospital or other health facility
4 and the Federally-owned quarters associated there-
5 with, pursuant to a funding agreement under the In-
6 dian Self-Determination and Education Assistance
7 Act, may establish the rental rates charged to the
8 occupants of such quarters by providing notice to
9 the Secretary of its election to exercise such author-
10 ity.
11 "(2) OBJECTIVES.—In establishing rental rates
12 under paragraph (1), an Indian tribe or tribal orga-
13 nization shall attempt to achieve the following objec-
14 tives:
15 "(A) The rental rates should be based on
16 the reasonable value of the quarters to the oc-
17 cupants thereof.
18 "(B) The rental rates should generate suf-
19 ficient funds to prudently provide for the oper-
20 ation and maintenance of the quarters, and,
21 subject to the discretion of the Indian tribe or
22 tribal organization, to supply reserve funds for
23 capital repairs and replacement of the quarters.
24 "(3) ELIGIBILITY FOR QUARTERS IMPROVE-
25 MENT AND REPAIR.—Any quarters whose rental

1 rates are established by an Indian tribe or tribal or-
2 ganization under this subsection shall continue to be
3 eligible for quarters improvement and repair funds
4 to the same extent as other Federally-owned quar-
5 ters that are used to house personnel in Service-sup-
6 ported programs.

7 "(4) NOTICE OF CHANGE IN RATES.—An In-
8 dian tribe or tribal organization that exercises the
9 authority provided under this subsection shall pro-
10 vide occupants with not less than 60 days notice of
11 any change in rental rates.

12 "(b) COLLECTION OF RENTS.—

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

21 "(A) The Indian tribe or tribal organiza-
22 tion shall notify the Secretary and the Federal
23 employees involved of its election to exercise its
24 authority to collect rents directly from such
25 Federal employees.

1 "(B) Upon the receipt of a notice described
2 in subparagraph (A), the Federal employees in-
3 volved shall pay rents for the occupancy of such
4 quarters directly to the Indian tribe or tribal
5 organization and the Secretary shall have no
6 further authority to collect rents from such em-
7 ployees through payroll deduction or otherwise.
8 "(C) Such rent payments shall be retained
9 by the Indian tribe or tribal organization and
10 shall not be made payable to or otherwise be
11 deposited with the United States.
12 "(D) Such rent payments shall be depos-
13 ited into a separate account which shall be used
14 by the Indian tribe or tribal organization for
15 the maintenance (including capital repairs and
16 replacement expenses) and operation of the
17 quarters and facilities as the Indian tribe or
18 tribal organization shall determine appropriate.
19 "(2) RETROCESSION.—If an Indian tribe or
20 tribal organization which has made an election under
21 paragraph (1) requests retrocession of its authority
22 to directly collect rents from Federal employees oc-
23 cupying Federally-owned quarters, such retrocession
24 shall become effective on the earlier of—

1 "(A) the first day of the month that begins
2 not less than 180 days after the Indian tribe or
3 tribal organization notifies the Secretary of its
4 desire to retrocede; or
5 "(B) such other date as may be mutually
6 agreed upon by the Secretary and the Indian
7 tribe or tribal organization.
8 "(c) RATES.—To the extent that an Indian tribe or
9 tribal organization, pursuant to authority granted in sub-
10 section (a), establishes rental rates for Federally-owned
11 quarters provided to a Federal employee in Alaska, such
12 rents may be based on the cost of comparable private rent-
13 al housing in the nearest established community with a
14 year-round population of 1,500 or more individuals.–
15 **"SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIRE-**
16 **MENT.**
17 "(a) IN GENERAL.—The Secretary shall ensure that
18 the requirements of the Buy American Act apply to all
19 procurements made with funds provided pursuant to the
20 authorization contained in section 318, except that Indian
21 tribes and tribal organizations shall be exempt from such
22 requirements.
23 "(b) FALSE OR MISLEADING LABELING.—If it has
24 been finally determined by a court or Federal agency that
25 any person intentionally affixed a label bearing a 'Made

1 in America' inscription, or any inscription with the same
2 meaning, to any product sold in or shipped to the United
3 States that is not made in the United States, such person
4 shall be ineligible to receive any contract or subcontract
5 made with funds provided pursuant to the authorization
6 contained in section 318, pursuant to the debarment, sus-
7 pension, and ineligibility procedures described in sections
8 9.400 through 9.409 of title 48, Code of Federal Regula-
9 tions.

10 (c) DEFINITION.—In this section, the term 'Buy
11 American Act' means title III of the Act entitled 'An Act
12 making appropriations for the Treasury and Post Office
13 Departments for the fiscal year ending June 30, 1934,
14 and for other purposes', approved March 3, 1933 (41
15 U.S.C. 10a et seq.).

16 **"SEC. 317. OTHER FUNDING FOR FACILITIES.**

17 "Notwithstanding any other provision of law—

18 "(1) the Secretary may accept from any source,
19 including Federal and State agencies, funds that are
20 available for the construction of health care facilities
21 and use such funds to plan, design and construct
22 health care facilities for Indians and to place such
23 funds into funding agreements authorized under the
24 Indian Self-Determination and Education Assistance
25 Act (25 U.S.C. 450f et seq.) between the Secretary

1 and an Indian tribe or tribal organization, except
2 that the receipt of such funds shall not have an ef-
3 fect on the priorities established pursuant to section
4 301;

5 "(2) the Secretary may enter into interagency
6 agreements with other Federal or State agencies and
7 other entities and to accept funds from such Federal
8 or State agencies or other entities to provide for the
9 planning, design and construction of health care fa-
10 cilities to be administered by the Service or by In-
11 dian tribes or tribal organizations under the Indian
12 Self-Determination and Education Assistance Act in
13 order to carry out the purposes of this Act, together
14 with the purposes for which such funds are appro-
15 priated to such other Federal or State agency or for
16 which the funds were otherwise provided;

17 "(3) any Federal agency to which funds for the
18 construction of health care facilities are appropriated
19 is authorized to transfer such funds to the Secretary
20 for the construction of health care facilities to carry
21 out the purposes of this Act as well as the purposes
22 for which such funds are appropriated to such other
23 Federal agency; and

24 "(4) the Secretary, acting through the Service,
25 shall establish standards under regulations developed

1 through rulemaking under section 802, for the plan-
2 ning, design and construction of health care facilities
3 serving Indians under this Act.

4 **"SEC. 318. AUTHORIZATION OF APPROPRIATIONS.**

5 "There is authorized to be appropriated such sums
6 as may be necessary for each fiscal year through fiscal
7 year 2012 to carry out this title.

8 "TITLE IV—ACCESS TO HEALTH 9 SERVICES

10 **"SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE**
11 **PROGRAM.**

12 "(a) IN GENERAL.—Any payments received by the
13 Service, by an Indian tribe or tribal organization pursuant
14 to a funding agreement under the Indian Self-Determina-
15 tion and Education Assistance Act, or by an urban Indian
16 organization pursuant to title V of this Act for services
17 provided to Indians eligible for benefits under title XVIII
18 of the Social Security Act shall not be considered in deter-
19 mining appropriations for health care and services to Indi-
20 ans.

21 "(b) EQUAL TREATMENT.—Nothing in this Act au-
22 thorizes the Secretary to provide services to an Indian ben-
23 eficiary with coverage under title XVIII of the Social Secu-
24 rity Act in preference to an Indian beneficiary without
25 such coverage.

1 "(c) SPECIAL FUND.—

2 "(1) USE OF FUNDS.—Notwithstanding any
3 other provision of this title or of title XVIII of the
4 Social Security Act, payments to which any facility
5 of the Service is entitled by reason of this section
6 shall be placed in a special fund to be held by the
7 Secretary and first used (to such extent or in such
8 amounts as are provided in appropriation Acts) for
9 the purpose of making any improvements in the pro-
10 grams of the Service which may be necessary to
11 achieve or maintain compliance with the applicable
12 conditions and requirements of this title and of title
13 XVIII of the Social Security Act. Any funds to be
14 reimbursed which are in excess of the amount nec-
15 essary to achieve or maintain such conditions and
16 requirements shall, subject to the consultation with
17 tribes being served by the service unit, be used for
18 reducing the health resource deficiencies of the In-
19 dian tribes.

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

1 **"SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID**
2 **PROGRAM.**
3 "(a) SPECIAL FUND.—
4 "(1) USE OF FUNDS.—Notwithstanding any
5 other provision of law, payments to which any facil-
6 ity of the Service (including a hospital, nursing facil-
7 ity, intermediate care facility for the mentally re-
8 tarded, or any other type of facility which provides
9 services for which payment is available under title
10 XIX of the Social Security Act) is entitled under a
11 State plan by reason of section 1911 of such Act
12 shall be placed in a special fund to be held by the
13 Secretary and first used (to such extent or in such
14 amounts as are provided in appropriation Acts) for
15 the purpose of making any improvements in the fa-
16 cilities of such Service which may be necessary to
17 achieve or maintain compliance with the applicable
18 conditions and requirements of such title. Any pay-
19 ments which are in excess of the amount necessary
20 to achieve or maintain such conditions and require-
21 ments shall, subject to the consultation with tribes
22 being served by the service unit, be used for reduc-
23 ing the health resource deficiencies of the Indian
24 tribes. In making payments from such fund, the Sec-
25 retary shall ensure that each service unit of the
26 Service receives 100 percent of the amounts to which

1 the facilities of the Service, for which such service
2 unit makes collections, are entitled by reason of sec-
3 tion 1911 of the Social Security Act.

4 "(2) NONAPPLICATION IN CASE OF ELECTION
5 FOR DIRECT BILLING.—Paragraph (1) shall not
6 apply upon the election of an Indian tribe or tribal
7 organization under section 405 to receive direct pay-
8 ments for services provided to Indians eligible for
9 medical assistance under title XIX of the Social Se-
10 curity Act.

11 "(b) PAYMENTS DISREGARDED FOR APPROPRIA-
12 TIONS.—Any payments received under section 1911 of the
13 Social Security Act for services provided to Indians eligible
14 for benefits under title XIX of the Social Security Act
15 shall not be considered in determining appropriations for
16 the provision of health care and services to Indians.

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

23 **"SEC. 403. REPORT.**

24 "(a) INCLUSION IN ANNUAL REPORT.—The Sec-
25 retary shall submit to the President, for inclusion in the

1 report required to be transmitted to the Congress under
2 section 801, an accounting on the amount and use of
3 funds made available to the Service pursuant to this title
4 as a result of reimbursements under titles XVIII and XIX
5 of the Social Security Act.

6 "(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—
7 If an Indian tribe or tribal organization receives funding
8 from the Service under the Indian Self-Determination and
9 Education Assistance Act or an urban Indian organization
10 receives funding from the Service under Title V of this
11 Act and receives reimbursements or payments under title
12 XVIII, XIX, or XXI of the Social Security Act, such In-
13 dian tribe or tribal organization, or urban Indian organi-
14 zation, shall provide to the Service a list of each provider
15 enrollment number (or other identifier) under which it re-
16 ceives such reimbursements or payments.

17 **"SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH**
18 **THE SERVICE, INDIAN TRIBES OR TRIBAL OR-**
19 **GANIZATIONS, AND URBAN INDIAN ORGANI-**
20 **ZATIONS.**

21 "(a) IN GENERAL.—The Secretary shall make grants
22 to or enter into funding agreements with Indian tribes and
23 tribal organizations to assist such organizations in estab-
24 lishing and administering programs on or near Federal In-

1 dian reservations and trust areas and in or near Alaska
2 Native villages to assist individual Indians to—
3 "(1) enroll under sections 1818, 1836, and
4 1837 of the Social Security Act;
5 "(2) pay premiums for health insurance cov-
6 erage; and
7 "(3) apply for medical assistance provided pur-
8 suant to titles XIX and XXI of the Social Security
9 Act.
10 "(b) CONDITIONS.—The Secretary shall place condi-
11 tions as deemed necessary to effect the purpose of this
12 section in any funding agreement or grant which the Sec-
13 retary makes with any Indian tribe or tribal organization
14 pursuant to this section. Such conditions shall include, but
15 are not limited to, requirements that the organization suc-
16 cessfully undertake to—
17 "(1) determine the population of Indians to be
18 served that are or could be recipients of benefits or
19 assistance under titles XVIII, XIX, and XXI of the
20 Social Security Act;
21 "(2) assist individual Indians in becoming fa-
22 miliar with and utilizing such benefits and assist-
23 ance;

1 "(3) provide transportation to such individual
2 Indians to the appropriate offices for enrollment or
3 applications for such benefits and assistance;
4 "(4) develop and implement—
5 "(A) a schedule of income levels to deter-
6 mine the extent of payments of premiums by
7 such organizations for health insurance cov-
8 erage of needy individuals; and
9 "(B) methods of improving the participa-
10 tion of Indians in receiving the benefits and as-
11 sistance provided under titles XVIII, XIX, and
12 XXI of the Social Security Act.
13 "(c) AGREEMENTS FOR RECEIPT AND PROCESSING
14 OF APPLICATIONS.—The Secretary may enter into an
15 agreement with an Indian tribe or tribal organization, or
16 an urban Indian organization, which provides for the re-
17 ceipt and processing of applications for medical assistance
18 under title XIX of the Social Security Act, child health
19 assistance under title XXI of such Act and benefits under
20 title XVIII of such Act by a Service facility or a health
21 care program administered by such Indian tribe or tribal
22 organization, or urban Indian organization, pursuant to
23 a funding agreement under the Indian Self-Determination
24 and Education Assistance Act or a grant or contract en-
25 tered into with an urban Indian organization under title

1 V of this Act. Notwithstanding any other provision of law,
2 such agreements shall provide for reimbursement of the
3 cost of outreach, education regarding eligibility and bene-
4 fits, and translation when such services are provided. The
5 reimbursement may be included in an encounter rate or
6 be made on a fee-for-service basis as appropriate for the
7 provider. When necessary to carry out the terms of this
8 section, the Secretary, acting through the Health Care Fi-
9 nancing Administration or the Service, may enter into
10 agreements with a State (or political subdivision thereof)
11 to facilitate cooperation between the State and the Service,
12 an Indian tribe or tribal organization, and an urban In-
13 dian organization.

14 "(d) GRANTS.—

15 "(1) IN GENERAL.—The Secretary shall make
16 grants or enter into contracts with urban Indian or-
17 ganizations to assist such organizations in establish-
18 ing and administering programs to assist individual
19 urban Indians to—

20 "(A) enroll under sections 1818, 1836, and
21 1837 of the Social Security Act;

22 "(B) pay premiums on behalf of such indi-
23 viduals for coverage under title XVIII of such
24 Act; and

1 "(C) apply for medical assistance provided
2 under title XIX of such Act and for child health
3 assistance under title XXI of such Act.
4 "(2) REQUIREMENTS.—The Secretary shall in-
5 clude in the grants or contracts made or entered
6 into under paragraph (1) requirements that are—
7 "(A) consistent with the conditions im-
8 posed by the Secretary under subsection (b);
9 "(B) appropriate to urban Indian organi-
10 zations and urban Indians; and
11 "(C) necessary to carry out the purposes of
12 this section.

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

16 "(a) DIRECT BILLING.—
17 "(1) IN GENERAL.—An Indian tribe or tribal
18 organization may directly bill for, and receive pay-
19 ment for, health care services provided by such tribe
20 or organization for which payment is made under
21 title XVIII of the Social Security Act, under a State
22 plan for medical assistance approved under title XIX
23 of such Act, under a State child health plan ap-
24 proved under title XXI of such Act, or from any
25 other third party payor.

1 "(2) APPLICATION OF 100 PERCENT FMAP.—
2 The third sentence of section 1905(b) of the Social
3 Security Act and section 2101(c) of such Act shall
4 apply for purposes of reimbursement under the med-
5 icaid or State children's health insurance program
6 for health care services directly billed under the pro-
7 gram established under this section.
8 "(b) DIRECT REIMBURSEMENT.—
9 "(1) USE OF FUNDS.—Each Indian tribe or
10 tribal organization exercising the option described in
11 subsection (a) of this section shall be reimbursed di-
12 rectly under the medicare, medicaid, and State chil-
13 dren's health insurance programs for services fur-
14 nished, without regard to the provisions of sections
15 1880(c) of the Social Security Act and section
16 402(a) of this Act, but all funds so reimbursed shall
17 first be used by the health program for the purpose
18 of making any improvements in the facility or health
19 programs that may be necessary to achieve or main-
20 tain compliance with the conditions and require-
21 ments applicable generally to such health services
22 under the medicare, medicaid, or State children's
23 health insurance program. Any funds so reimbursed
24 which are in excess of the amount necessary to
25 achieve or maintain such conditions or requirements

1 shall be used to provide additional health services,
2 improvements in its health care facilities, or other-
3 wise to achieve the health objectives provided for
4 under section 3 of this Act.

5 "(2) AUDITS.—The amounts paid to the health
6 programs exercising the option described in sub-
7 section (a) shall be subject to all auditing require-
8 ments applicable to programs administered directly
9 by the Service and to facilities participating in the
10 medicare, medicaid, and State children's health in-
11 surance programs.

12 "(3) NO PAYMENTS FROM SPECIAL FUNDS.—
13 Notwithstanding section 401(c) or section 402(a), no
14 payment may be made out of the special fund de-
15 scribed in section 401(c) or 402(a), for the benefit
16 of any health program exercising the option de-
17 scribed in subsection (a) of this section during the
18 period of such participation.

19 "(c) EXAMINATION AND IMPLEMENTATION OF
20 CHANGES.—The Secretary, acting through the Service,
21 and with the assistance of the Administrator of the Health
22 Care Financing Administration, shall examine on an ongo-
23 ing basis and implement any administrative changes that
24 may be necessary to facilitate direct billing and reimburse-
25 ment under the program established under this section,

1 including any agreements with States that may be nec-
2 essary to provide for direct billing under the medicaid or
3 State children's health insurance program.

4 "(d) WITHDRAWAL FROM PROGRAM.—A participant
5 in the program established under this section may with-
6 draw from participation in the same manner and under
7 the same conditions that an Indian tribe or tribal organi-
8 zation may retrocede a contracted program to the Sec-
9 retary under authority of the Indian Self-Determination
10 and Education Assistance Act. All cost accounting and
11 billing authority under the program established under this
12 section shall be returned to the Secretary upon the Sec-
13 retary's acceptance of the withdrawal of participation in
14 this program.

15 "(e) LIMITATION.—Notwithstanding this section, ab-
16 sent specific written authorization by the governing body
17 of an Indian tribe for the period of such authorization
18 (which may not be for a period of more than 1 year and
19 which may be revoked at any time upon written notice by
20 the governing body to the Service), neither the United
21 States through the Service, nor an Indian tribe or tribal
22 organization under a funding agreement pursuant to the
23 Indian Self-Determination and Education Assistance Act,
24 nor an urban Indian organization funded under title V,
25 shall have a right of recovery under this section if the in-

1 jury, illness, or disability for which health services were
2 provided is covered under a self-insurance plan funded by
3 an Indian tribe or tribal organization, or urban Indian or-
4 ganization. Where such tribal authorization is provided,
5 the Service may receive and expend such funds for the
6 provision of additional health services.

7 **"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PAR-**
8 **TIES OF COSTS OF HEALTH SERVICES.**

9 "(a) RIGHT OF RECOVERY.—Except as provided in
10 subsection (g), the United States, an Indian tribe or tribal
11 organization shall have the right to recover the reasonable
12 charges billed or expenses incurred by the Secretary or
13 an Indian tribe or tribal organization in providing health
14 services, through the Service or an Indian tribe or tribal
15 organization to any individual to the same extent that
16 such individual, or any nongovernmental provider of such
17 services, would be eligible to receive reimbursement or in-
18 demnification for such charges or expenses if—

19 "(1) such services had been provided by a non-
20 governmental provider; and

21 "(2) such individual had been required to pay
22 such charges or expenses and did pay such expenses.

23 "(b) URBAN INDIAN ORGANIZATIONS.—Except as
24 provided in subsection (g), an urban Indian organization
25 shall have the right to recover the reasonable charges

1 billed or expenses incurred by the organization in provid-
2 ing health services to any individual to the same extent
3 that such individual, or any other nongovernmental pro-
4 vider of such services, would be eligible to receive reim-
5 bursement or indemnification for such charges or expenses
6 if such individual had been required to pay such charges
7 or expenses and did pay such charges or expenses.

8 "(c) LIMITATIONS ON RECOVERIES FROM STATES.—
9 Subsections (a) and (b) shall provide a right of recovery
10 against any State, only if the injury, illness, or disability
11 for which health services were provided is covered under—

12 "(1) workers' compensation laws; or

13 "(2) a no-fault automobile accident insurance
14 plan or program.

15 "(d) NONAPPLICATION OF OTHER LAWS.—No law of
16 any State, or of any political subdivision of a State and
17 no provision of any contract entered into or renewed after
18 the date of enactment of the Indian Health Care Amend-
19 ments of 1988, shall prevent or hinder the right of recov-
20 ery of the United States or an Indian tribe or tribal orga-
21 nization under subsection (a), or an urban Indian organi-
22 zation under subsection (b).

23 "(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—
24 No action taken by the United States or an Indian tribe
25 or tribal organization to enforce the right of recovery pro-

1 vided under subsection (a), or by an urban Indian organi-
2 zation to enforce the right of recovery provided under sub-
3 section (b), shall affect the right of any person to any
4 damages (other than damages for the cost of health serv-
5 ices provided by the Secretary through the Service).

6 "(f) METHODS OF ENFORCEMENT.—

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

12 "(A) intervening or joining in any civil ac-
13 tion or proceeding brought—

14 "(i) by the individual for whom health
15 services were provided by the Secretary, an
16 Indian tribe or tribal organization, or
17 urban Indian organization; or

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

20 "(B) instituting a civil action.

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

1 "(g) LIMITATION.—Notwithstanding this section, ab-
2 sent specific written authorization by the governing body
3 of an Indian tribe for the period of such authorization
4 (which may not be for a period of more than 1 year and
5 which may be revoked at any time upon written notice by
6 the governing body to the Service), neither the United
7 States through the Service, nor an Indian tribe or tribal
8 organization under a funding agreement pursuant to the
9 Indian Self-Determination and Education Assistance Act,
10 nor an urban Indian organization funded under title V,
11 shall have a right of recovery under this section if the in-
12 jury, illness, or disability for which health services were
13 provided is covered under a self-insurance plan funded by
14 an Indian tribe or tribal organization, or urban Indian or-
15 ganization. Where such tribal authorization is provided,
16 the Service may receive and expend such funds for the
17 provision of additional health services.

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

22 "(i) RIGHT OF ACTION AGAINST INSURERS AND EM-
23 PLOYEE BENEFIT PLANS.—

24 "(1) IN GENERAL.—Where an insurance com-
25 pany or employee benefit plan fails or refuses to pay

1 the amount due under subsection (a) for services
2 provided to an individual who is a beneficiary, par-
3 ticipant, or insured of such company or plan, the
4 United States or an Indian tribe or tribal organiza-
5 tion shall have a right to assert and pursue all the
6 claims and remedies against such company or plan,
7 and against the fiduciaries of such company or plan,
8 that the individual could assert or pursue under ap-
9 plicable Federal, State or tribal law.

10 "(2) URBAN INDIAN ORGANIZATIONS.—Where
11 an insurance company or employee benefit plan fails
12 or refuses to pay the amounts due under subsection
13 (b) for health services provided to an individual who
14 is a beneficiary, participant, or insured of such com-
15 pany or plan, the urban Indian organization shall
16 have a right to assert and pursue all the claims and
17 remedies against such company or plan, and against
18 the fiduciaries of such company or plan, that the in-
19 dividual could assert or pursue under applicable
20 Federal or State law.

21 "(j) NONAPPLICATION OF CLAIMS FILING REQUIRE-
22 MENTS.—Notwithstanding any other provision in law, the
23 Service, an Indian tribe or tribal organization, or an urban
24 Indian organization shall have a right of recovery for any
25 otherwise reimbursable claim filed on a current HCFA-

1 1500 or UB–92 form, or the current NSF electronic for-
2 mat, or their successors. No health plan shall deny pay-
3 ment because a claim has not been submitted in a unique
4 format that differs from such forms.

5 **"SEC. 407. CREDITING OF REIMBURSEMENTS.**

6 "(a) RETENTION OF FUNDS.—Except as provided in
7 section 202(d), this title, and section 807, all reimburse-
8 ments received or recovered under the authority of this
9 Act, Public Law 87–693, or any other provision of law,
10 by reason of the provision of health services by the Service
11 or by an Indian tribe or tribal organization under a fund-
12 ing agreement pursuant to the Indian Self-Determination
13 and Education Assistance Act, or by an urban Indian or-
14 ganization funded under title V, shall be retained by the
15 Service or that tribe or tribal organization and shall be
16 available for the facilities, and to carry out the programs,
17 of the Service or that tribe or tribal organization to pro-
18 vide health care services to Indians.

19 "(b) NO OFFSET OF FUNDS.—The Service may not
20 offset or limit the amount of funds obligated to any service
21 unit or entity receiving funding from the Service because
22 of the receipt of reimbursements under subsection (a).

23 **"SEC. 408. PURCHASING HEALTH CARE COVERAGE.**

24 "An Indian tribe or tribal organization, and an urban
25 Indian organization may utilize funding from the Sec-

1 retary under this Act to purchase managed care coverage
2 for Service beneficiaries (including insurance to limit the
3 financial risks of managed care entities) from—
4 "(1) a tribally owned and operated managed
5 care plan;
6 "(2) a State or locally-authorized or licensed
7 managed care plan; or
8 "(3) a health insurance provider.

9 **"SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VET-**
10 **ERAN'S AFFAIRS, AND OTHER FEDERAL**
11 **AGENCY HEALTH FACILITIES AND SERVICES**
12 **SHARING.**

13 "(a) EXAMINATION OF FEASIBILITY OF ARRANGE-
14 MENTS.—
15 "(1) IN GENERAL.—The Secretary shall exam-
16 ine the feasibility of entering into arrangements or
17 expanding existing arrangements for the sharing of
18 medical facilities and services between the Service
19 and the Veterans' Administration, and other appro-
20 priate Federal agencies, including those within the
21 Department, and shall, in accordance with sub-
22 section (b), prepare a report on the feasibility of
23 such arrangements.

1 "(2) SUBMISSION OF REPORT.—Not later than
2 September 30, 2000, the Secretary shall submit the
3 report required under paragraph (1) to Congress.
4 "(3) CONSULTATION REQUIRED.—The Sec-
5 retary may not finalize any arrangement described
6 in paragraph (1) without first consulting with the
7 affected Indian tribes.
8 "(b) LIMITATIONS.—The Secretary shall not take
9 any action under this section or under subchapter IV of
10 chapter 81 of title 38, United States Code, which would
11 impair—
12 "(1) the priority access of any Indian to health
13 care services provided through the Service;
14 "(2) the quality of health care services provided
15 to any Indian through the Service;
16 "(3) the priority access of any veteran to health
17 care services provided by the Veterans' Administra-
18 tion;
19 "(4) the quality of health care services provided
20 to any veteran by the Veteran's Administration;
21 "(5) the eligibility of any Indian to receive
22 health services through the Service; or
23 "(6) the eligibility of any Indian who is a vet-
24 eran to receive health services through the Veterans'
25 Administration provided, however, the Service or the

1 Indian tribe or tribal organization shall be reim-
2 bursed by the Veterans' Administration where serv-
3 ices are provided through the Service or Indian
4 tribes or tribal organizations to beneficiaries eligible
5 for services from the Veterans' Administration, not-
6 withstanding any other provision of law.

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

13 **"SEC. 410. PAYOR OF LAST RESORT.**

14 "The Service, and programs operated by Indian
15 tribes or tribal organizations, or urban Indian organiza-
16 tions shall be the payor of last resort for services provided
17 to individuals eligible for services from the Service and
18 such programs, notwithstanding any Federal, State or
19 local law to the contrary, unless such law explicitly pro-
20 vides otherwise.

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

23 "Notwithstanding any other provision of law, the
24 Service, Indian tribes or tribal organizations, and urban
25 Indian organizations (notwithstanding limitations on who

1 is eligible to receive services from such entities) shall be
2 entitled to receive payment or reimbursement for services
3 provided by such entities from any Federally funded
4 health care program, unless there is an explicit prohibition
5 on such payments in the applicable authorizing statute.

6 **"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.**

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

11 "(1) enter into a demonstration project with the
12 State of Arizona under which the Service would pro-
13 vide certain specified medicaid services to individuals
14 dually eligible for services from the Service and for
15 medical assistance under title XIX of the Social Se-
16 curity Act in return for payment on a capitated
17 basis from the State of Arizona; and

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

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

1 **"SEC. 413. ACCESS TO FEDERAL INSURANCE.**

2 "Notwithstanding the provisions of title 5, United
3 States Code, Executive Order, or administrative regula-
4 tion, an Indian tribe or tribal organization carrying out
5 programs under the Indian Self-Determination and Edu-
6 cation Assistance Act or an urban Indian organization car-
7 rying out programs under title V of this Act shall be enti-
8 tled to purchase coverage, rights and benefits for the em-
9 ployees of such Indian tribe or tribal organization, or
10 urban Indian organization, under chapter 89 of title 5,
11 United States Code, and chapter 87 of such title if nec-
12 essary employee deductions and agency contributions in
13 payment for the coverage, rights, and benefits for the pe-
14 riod of employment with such Indian tribe or tribal organi-
15 zation, or urban Indian organization, are currently depos-
16 ited in the applicable Employee's Fund under such title.

17 **"SEC. 414. CONSULTATION AND RULEMAKING.**

18 "(a) CONSULTATION.—Prior to the adoption of any
19 policy or regulation by the Health Care Financing Admin-
20 istration, the Secretary shall require the Administrator of
21 that Administration to—

22 "(1) identify the impact such policy or regula-
23 tion may have on the Service, Indian tribes or tribal
24 organizations, and urban Indian organizations;

1 "(2) provide to the Service, Indian tribes or
2 tribal organizations, and urban Indian organizations
3 the information described in paragraph (1);
4 "(3) engage in consultation, consistent with the
5 requirements of Executive Order 13084 of May 14,
6 1998, with the Service, Indian tribes or tribal orga-
7 nizations, and urban Indian organizations prior to
8 enacting any such policy or regulation.
9 "(b) RULEMAKING.—The Administrator of the
10 Health Care Financing Administration shall participate in
11 the negotiated rulemaking provided for under title VIII
12 with regard to any regulations necessary to implement the
13 provisions of this title that relate to the Social Security
14 Act.
15 **"SEC. 415. LIMITATIONS ON CHARGES.**
16 "No provider of health services that is eligible to re-
17 ceive payments or reimbursements under titles XVIII,
18 XIX, or XXI of the Social Security Act or from any Feder-
19 ally funded (whether in whole or part) health care pro-
20 gram may seek to recover payment for services—
21 "(1) that are covered under and furnished to an
22 individual eligible for the contract health services
23 program operated by the Service, by an Indian tribe
24 or tribal organization, or furnished to an urban In-
25 dian eligible for health services purchased by an

1 urban Indian organization, in an amount in excess
2 of the lowest amount paid by any other payor for
3 comparable services; or
4 "(2) for examinations or other diagnostic proce-
5 dures that are not medically necessary if such proce-
6 dures have already been performed by the referring
7 Indian health program and reported to the provider.

8 **"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHOR-**
9 **ITY.**

10 "Notwithstanding any other provision of law, the Sec-
11 retary may not waive the application of section
12 1902(a)(13)(D) of the Social Security Act to any State
13 plan under title XIX of the Social Security Act.

14 **"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANC-**
15 **TIONS.**

16 "Notwithstanding any other provision of law, the
17 Service or an Indian tribe or tribal organization or an
18 urban Indian organization operating a health program
19 under the Indian Self-Determination and Education As-
20 sistance Act shall be entitled to seek a waiver of sanctions
21 imposed under title XVIII, XIX, or XXI of the Social Se-
22 curity Act as if such entity were directly responsible for
23 administering the State health care program.

1 **"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES**
2 **OF SAFE HARBOR PROVISIONS; ANTITRUST**
3 **IMMUNITY.**
4 "(a) MEANING OF REMUNERATION.—Notwithstand-
5 ing any other provision of law, the term 'remuneration'
6 as used in sections 1128A and 1128B of the Social Secu-
7 rity Act shall not include any exchange of anything of
8 value between or among—
9 "(1) any Indian tribe or tribal organization or
10 an urban Indian organization that administers
11 health programs under the authority of the Indian
12 Self-Determination and Education Assistance Act;
13 "(2) any such Indian tribe or tribal organiza-
14 tion or urban Indian organization and the Service;
15 "(3) any such Indian tribe or tribal organiza-
16 tion or urban Indian organization and any patient
17 served or eligible for service under such programs,
18 including patients served or eligible for service pur-
19 suant to section 813 of this Act (as in effect on the
20 day before the date of enactment of the Indian
21 Health Care Improvement Act Reauthorization of
22 2000); or
23 "(4) any such Indian tribe or tribal organiza-
24 tion or urban Indian organization and any third
25 party required by contract, section 206 or 207 of
26 this Act (as so in effect), or other applicable law, to

1 pay or reimburse the reasonable health care costs in-
2 curred by the United States or any such Indian tribe
3 or tribal organization or urban Indian organization;
4 provided the exchange arises from or relates to such health
5 programs.

6 "(b) ANTITRUST IMMUNITY.—An Indian tribe or
7 tribal organization or an urban Indian organization that
8 administers health programs under the authority of the
9 Indian Self-Determination and Education Assistance Act
10 or title V shall be deemed to be an agency of the United
11 States and immune from liability under the Acts com-
12 monly known as the Sherman Act, the Clayton Act, the
13 Robinson-Patman Anti-Discrimination Act, the Federal
14 Trade Commission Act, and any other Federal, State, or
15 local antitrust laws, with regard to any transaction, agree-
16 ment, or conduct that relates to such programs.

17 **"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES**
18 **AND PREMIUMS.**

19 "(a) EXEMPTION FROM COST-SHARING REQUIRE-
20 MENTS.—Notwithstanding any other provision of Federal
21 or State law, no Indian who is eligible for services under
22 title XVIII, XIX, or XXI of the Social Security Act, or
23 under any other Federally funded health care programs,
24 may be charged a deductible, co-payment, or co-insurance
25 for any service provided by or through the Service, an In-

1 dian tribe or tribal organization or urban Indian organiza-
2 tion, nor may the payment or reimbursement due to the
3 Service or an Indian tribe or tribal organization or urban
4 Indian organization be reduced by the amount of the de-
5 ductible, co-payment, or co-insurance that would be due
6 from the Indian but for the operation of this section. For
7 the purposes of this section, the term 'through' shall in-
8 clude services provided directly, by referral, or under con-
9 tracts or other arrangements between the Service, an In-
10 dian tribe or tribal organization or an urban Indian orga-
11 nization and another health provider.

12 "(b) EXEMPTION FROM PREMIUMS.—

13 "(1) MEDICAID AND STATE CHILDREN'S
14 HEALTH INSURANCE PROGRAM.—Notwithstanding
15 any other provision of Federal or State law, no In-
16 dian who is otherwise eligible for medical assistance
17 under title XIX of the Social Security Act or child
18 health assistance under title XXI of such Act may
19 be charged a premium as a condition of receiving
20 such assistance under title XIX of XXI of such Act.

21 "(2) MEDICARE ENROLLMENT PREMIUM PEN-
22 ALTIES.—Notwithstanding section 1839(b) of the
23 Social Security Act or any other provision of Federal
24 or State law, no Indian who is eligible for benefits
25 under part B of title XVIII of the Social Security

1 Act, but for the payment of premiums, shall be
2 charged a penalty for enrolling in such part at a
3 time later than the Indian might otherwise have
4 been first eligible to do so. The preceding sentence
5 applies whether an Indian pays for premiums under
6 such part directly or such premiums are paid by an-
7 other person or entity, including a State, the Serv-
8 ice, an Indian Tribe or tribal organization, or an
9 urban Indian organization.

10 **"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR**
11 **PURPOSES OF MEDICALLY NEEDY MEDICAID**
12 **ELIGIBILITY.**

13 "For the purpose of determining the eligibility under
14 section 1902(a)(10)(A)(ii)(IV) of the Social Security Act
15 of an Indian for medical assistance under a State plan
16 under title XIX of such Act, the cost of providing services
17 to an Indian in a health program of the Service, an Indian
18 Tribe or tribal organization, or an urban Indian organiza-
19 tion shall be deemed to have been an expenditure for
20 health care by the Indian.

21 **"SEC. 421. ESTATE RECOVERY PROVISIONS.**

22 "Notwithstanding any other provision of Federal or
23 State law, the following property may not be included
24 when determining eligibility for services or implementing
25 estate recovery rights under title XVIII, XIX, or XXI of

1 the Social Security Act, or any other health care programs
2 funded in whole or part with Federal funds:
3 "(1) Income derived from rents, leases, or roy-
4 alties of property held in trust for individuals by the
5 Federal Government.
6 "(2) Income derived from rents, leases, royal-
7 ties, or natural resources (including timber and fish-
8 ing activities) resulting from the exercise of Feder-
9 ally protected rights, whether collected by an individ-
10 ual or a tribal group and distributed to individuals.
11 "(3) Property, including interests in real prop-
12 erty currently or formerly held in trust by the Fed-
13 eral Government which is protected under applicable
14 Federal, State or tribal law or custom from re-
15 course, including public domain allotments.
16 "(4) Property that has unique religious or cul-
17 tural significance or that supports subsistence or
18 traditional life style according to applicable tribal
19 law or custom.
20 **"SEC. 422. MEDICAL CHILD SUPPORT.**
21 "Notwithstanding any other provision of law, a par-
22 ent shall not be responsible for reimbursing the Federal
23 Government or a State for the cost of medical services pro-
24 vided to a child by or through the Service, an Indian tribe
25 or tribal organization or an urban Indian organization.

1 For the purposes of this subsection, the term 'through'
2 includes services provided directly, by referral, or under
3 contracts or other arrangements between the Service, an
4 Indian Tribe or tribal organization or an urban Indian or-
5 ganization and another health provider.

6 **"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.**

7 "(a) RECOVERY FROM MANAGED CARE PLANS.—
8 Notwithstanding any other provision in law, the Service,
9 an Indian Tribe or tribal organization or an urban Indian
10 organization shall have a right of recovery under section
11 408 from all private and public health plans or programs,
12 including the medicare, medicaid, and State children's
13 health insurance programs under titles XVIII, XIX, and
14 XXI of the Social Security Act, for the reasonable costs
15 of delivering health services to Indians entitled to receive
16 services from the Service, an Indian Tribe or tribal organi-
17 zation or an urban Indian organization.

18 "(b) LIMITATION.—No provision of law or regulation,
19 or of any contract, may be relied upon or interpreted to
20 deny or reduce payments otherwise due under subsection
21 (a), except to the extent the Service, an Indian tribe or
22 tribal organization, or an urban Indian organization has
23 entered into an agreement with a managed care entity re-
24 garding services to be provided to Indians or rates to be
25 paid for such services, provided that such an agreement

1 may not be made a prerequisite for such payments to be
2 made.

3 "(c) PARITY.—Payments due under subsection (a)
4 from a managed care entity may not be paid at a rate
5 that is less than the rate paid to a 'preferred provider'
6 by the entity or, in the event there is no such rate, the
7 usual and customary fee for equivalent services.

8 "(d) NO CLAIM REQUIREMENT.—A managed care
9 entity may not deny payment under subsection (a) because
10 an enrollee with the entity has not submitted a claim.

11 "(e) DIRECT BILLING.—Notwithstanding the preced-
12 ing subsections of this section, the Service, an Indian tribe
13 or tribal organization, or an urban Indian organization
14 that provides a health service to an Indian entitled to med-
15 ical assistance under the State plan under title XIX of
16 the Social Security Act or enrolled in a child health plan
17 under title XXI of such Act shall have the right to be
18 paid directly by the State agency administering such plans
19 notwithstanding any agreements the State may have en-
20 tered into with managed care organizations or providers.

21 "(f) REQUIREMENT FOR MEDICAID MANAGED CARE
22 ENTITIES.—A managed care entity (as defined in section
23 1932(a)(1)(B) of the Social Security Act shall, as a condi-
24 tion of participation in the State plan under title XIX of
25 such Act, offer a contract to health programs administered

1 by the Service, an Indian tribe or tribal organization or
2 an urban Indian organization that provides health services
3 in the geographic area served by the managed care entity
4 and such contract (or other provider participation agree-
5 ment) shall contain terms and conditions of participation
6 and payment no more restrictive or onerous than those
7 provided for in this section.

8 "(g) PROHIBITION.—Notwithstanding any other pro-
9 vision of law or any waiver granted by the Secretary no
10 Indian may be assigned automatically or by default under
11 any managed care entity participating in a State plan
12 under title XIX or XXI of the Social Security Act unless
13 the Indian had the option of enrolling in a managed care
14 plan or health program administered by the Service, an
15 Indian tribe or tribal organization, or an urban Indian or-
16 ganization.

17 "(h) INDIAN MANAGED CARE PLANS.—Notwith-
18 standing any other provision of law, any State entering
19 into agreements with one or more managed care organiza-
20 tions to provide services under title XIX or XXI of the
21 Social Security Act shall enter into such an agreement
22 with the Service, an Indian tribe or tribal organization or
23 an urban Indian organization under which such an entity
24 may provide services to Indians who may be eligible or
25 required to enroll with a managed care organization

1 through enrollment in an Indian managed care organiza-
2 tion that provides services similar to those offered by other
3 managed care organizations in the State. The Secretary
4 and the State are hereby authorized to waive requirements
5 regarding discrimination, capitalization, and other matters
6 that might otherwise prevent an Indian managed care or-
7 ganization or health program from meeting Federal or
8 State standards applicable to such organizations, provided
9 such Indian managed care organization or health program
10 offers Indian enrollees services of an equivalent quality to
11 that required of other managed care organizations.

12 "(i) ADVERTISING.—A managed care organization
13 entering into a contract to provide services to Indians on
14 or near an Indian reservation shall provide a certificate
15 of coverage or similar type of document that is written
16 in the Indian language of the majority of the Indian popu-
17 lation residing on such reservation.

18 **"SEC. 424. NAVAJO NATION MEDICAID AGENCY.**

19 "(a) IN GENERAL.—Notwithstanding any other pro-
20 vision of law, the Secretary may treat the Navajo Nation
21 as a State under title XIX of the Social Security Act for
22 purposes of providing medical assistance to Indians living
23 within the boundaries of the Navajo Nation.

24 "(b) ASSIGNMENT AND PAYMENT.—Notwithstanding
25 any other provision of law, the Secretary may assign and

1 pay all expenditures related to the provision of services
2 to Indians living within the boundaries of the Navajo Na-
3 tion under title XIX of the Social Security Act (including
4 administrative expenditures) that are currently paid to or
5 would otherwise be paid to the States of Arizona, New
6 Mexico, and Utah, to an entity established by the Navajo
7 Nation and approved by the Secretary, which shall be de-
8 nominated the Navajo Nation Medicaid Agency.

9 "(c) AUTHORITY.—The Navajo Nation Medicaid
10 Agency shall serve Indians living within the boundaries of
11 the Navajo Nation and shall have the same authority and
12 perform the same functions as other State agency respon-
13 sible for the administration of the State plan under title
14 XIX of the Social Security Act.

15 "(d) TECHNICAL ASSISTANCE.—The Secretary may
16 directly assist the Navajo Nation in the development and
17 implementation of a Navajo Nation Medicaid Agency for
18 the administration, eligibility, payment, and delivery of
19 medical assistance under title XIX of the Social Security
20 Act (which shall, for purposes of reimbursement to such
21 Nation, include Western and traditional Navajo healing
22 services) within the Navajo Nation. Such assistance may
23 include providing funds for demonstration projects con-
24 ducted with such Nation.

1 "(e) FMAP.—Notwithstanding section 1905(b) of
2 the Social Security Act, the Federal medical assistance
3 percentage shall be 100 per cent with respect to amounts
4 the Navajo Nation Medicaid agency expends for medical
5 assistance and related administrative costs.

6 "(f) WAIVER AUTHORITY.—The Secretary shall have
7 the authority to waive applicable provisions of Title XIX
8 of the Social Security Act to establish, develop and imple-
9 ment the Navajo Nation Medicaid Agency.

10 "(g) SCHIP.—At the option of the Navajo Nation,
11 the Secretary may treat the Navajo Nation as a State for
12 purposes of title XXI of the Social Security Act under
13 terms equivalent to those described in the preceding sub-
14 sections of this section.

15 **"SEC. 425. INDIAN ADVISORY COMMITTEES.**

16 "(a) NATIONAL INDIAN TECHNICAL ADVISORY
17 GROUP.—The Administrator of the Health Care Financ-
18 ing Administration shall establish and fund the expenses
19 of a National Indian Technical Advisory Group which shall
20 have no fewer than 14 members, including at least 1 mem-
21 ber designated by the Indian tribes and tribal organiza-
22 tions in each service area, 1 urban Indian organization
23 representative, and 1 member representing the Service.
24 The scope of the activities of such group shall be estab-
25 lished under section 802 provided that such scope shall

1 include providing comment on and advice regarding the
2 programs funded under titles XVIII, XIX, and XXI of the
3 Social Security Act or regarding any other health care pro-
4 gram funded (in whole or part) by the Health Care Fi-
5 nancing Administration.

6 "(b) INDIAN MEDICAID ADVISORY COMMITTEES.—
7 The Administrator of the Health Care Financing Adminis-
8 tration shall establish and provide funding for a Indian
9 Medicaid Advisory Committee made up of designees of the
10 Service, Indian tribes and tribal organizations and urban
11 Indian organizations in each State in which the Service
12 directly operates a health program or in which there is
13 one or more Indian tribe or tribal organization or urban
14 Indian organization.

15 **"SEC. 426. AUTHORIZATION OF APPROPRIATIONS.**

16 There is authorized to be appropriated such sums as
17 may be necessary for each of fiscal years 2000 through
18 2012 to carry out this title.".

19 "TITLE V—HEALTH SERVICES
20 FOR URBAN INDIANS

21 **"SEC. 501. PURPOSE.**

22 "The purpose of this title is to establish programs
23 in urban centers to make health services more accessible
24 and available to urban Indians.

1 **"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN IN-**
2 **DIAN ORGANIZATIONS.**

3 "Under the authority of the Act of November 2, 1921
4 (25 U.S.C. 13)(commonly known as the Snyder Act), the
5 Secretary, through the Service, shall enter into contracts
6 with, or make grants to, urban Indian organizations to
7 assist such organizations in the establishment and admin-
8 istration, within urban centers, of programs which meet
9 the requirements set forth in this title. The Secretary,
10 through the Service, subject to section 506, shall include
11 such conditions as the Secretary considers necessary to ef-
12 fect the purpose of this title in any contract which the
13 Secretary enters into with, or in any grant the Secretary
14 makes to, any urban Indian organization pursuant to this
15 title.

16 **"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION**
17 **OF HEALTH CARE AND REFERRAL SERVICES.**

18 "(a) AUTHORITY.—Under the authority of the Act of
19 November 2, 1921 (25 U.S.C. 13) (commonly known as
20 the Snyder Act), the Secretary, acting through the Serv-
21 ice, shall enter into contracts with, and make grants to,
22 urban Indian organizations for the provision of health care
23 and referral services for urban Indians. Any such contract
24 or grant shall include requirements that the urban Indian
25 organization successfully undertake to—

1 "(1) estimate the population of urban Indians
2 residing in the urban center or centers that the or-
3 ganization proposes to serve who are or could be re-
4 cipients of health care or referral services;
5 "(2) estimate the current health status of
6 urban Indians residing in such urban center or cen-
7 ters;
8 "(3) estimate the current health care needs of
9 urban Indians residing in such urban center or cen-
10 ters;
11 "(4) provide basic health education, including
12 health promotion and disease prevention education,
13 to urban Indians;
14 "(5) make recommendations to the Secretary
15 and Federal, State, local, and other resource agen-
16 cies on methods of improving health service pro-
17 grams to meet the needs of urban Indians; and
18 "(6) where necessary, provide, or enter into
19 contracts for the provision of, health care services
20 for urban Indians.
21 "(b) CRITERIA.—The Secretary, acting through the
22 Service, shall by regulation adopted pursuant to section
23 520 prescribe the criteria for selecting urban Indian orga-
24 nizations to enter into contracts or receive grants under

1 this section. Such criteria shall, among other factors,
2 include—
3 "(1) the extent of unmet health care needs of
4 urban Indians in the urban center or centers in-
5 volved;
6 "(2) the size of the urban Indian population in
7 the urban center or centers involved;
8 "(3) the extent, if any, to which the activities
9 set forth in subsection (a) would duplicate any
10 project funded under this title;
11 "(4) the capability of an urban Indian organiza-
12 tion to perform the activities set forth in subsection
13 (a) and to enter into a contract with the Secretary
14 or to meet the requirements for receiving a grant
15 under this section;
16 "(5) the satisfactory performance and success-
17 ful completion by an urban Indian organization of
18 other contracts with the Secretary under this title;
19 "(6) the appropriateness and likely effectiveness
20 of conducting the activities set forth in subsection
21 (a) in an urban center or centers; and
22 "(7) the extent of existing or likely future par-
23 ticipation in the activities set forth in subsection (a)
24 by appropriate health and health-related Federal,
25 State, local, and other agencies.

1 "(c) HEALTH PROMOTION AND DISEASE PREVEN-
2 TION.—The Secretary, acting through the Service, shall
3 facilitate access to, or provide, health promotion and dis-
4 ease prevention services for urban Indians through grants
5 made to urban Indian organizations administering con-
6 tracts entered into pursuant to this section or receiving
7 grants under subsection (a).

8 "(d) IMMUNIZATION SERVICES.—

9 "(1) IN GENERAL.—The Secretary, acting
10 through the Service, shall facilitate access to, or pro-
11 vide, immunization services for urban Indians
12 through grants made to urban Indian organizations
13 administering contracts entered into, or receiving
14 grants, under this section.

15 "(3) DEFINITION.—In this section, the term
16 'immunization services' means services to provide
17 without charge immunizations against vaccine-pre-
18 ventable diseases.

19 "(e) MENTAL HEALTH SERVICES.—

20 "(1) IN GENERAL.—The Secretary, acting
21 through the Service, shall facilitate access to, or pro-
22 vide, mental health services for urban Indians
23 through grants made to urban Indian organizations
24 administering contracts entered into, or receiving
25 grants, under this section.

1 "(2) ASSESSMENT.—A grant may not be made
2 under this subsection to an urban Indian organiza-
3 tion until that organization has prepared, and the
4 Service has approved, an assessment of the mental
5 health needs of the urban Indian population con-
6 cerned, the mental health services and other related
7 resources available to that population, the barriers
8 to obtaining those services and resources, and the
9 needs that are unmet by such services and resources.
10 "(3) USE OF FUNDS.—Grants may be made
11 under this subsection—
12 "(A) to prepare assessments required
13 under paragraph (2);
14 "(B) to provide outreach, educational, and
15 referral services to urban Indians regarding the
16 availability of direct behavioral health services,
17 to educate urban Indians about behavioral
18 health issues and services, and effect coordina-
19 tion with existing behavioral health providers in
20 order to improve services to urban Indians;
21 "(C) to provide outpatient behavioral
22 health services to urban Indians, including the
23 identification and assessment of illness, thera-
24 peutic treatments, case management, support

1 groups, family treatment, and other treatment;
2 and
3 "(D) to develop innovative behavioral
4 health service delivery models which incorporate
5 Indian cultural support systems and resources.
6 "(f) CHILD ABUSE.—
7 "(1) IN GENERAL.—The Secretary, acting
8 through the Service, shall facilitate access to, or pro-
9 vide, services for urban Indians through grants to
10 urban Indian organizations administering contracts
11 entered into pursuant to this section or receiving
12 grants under subsection (a) to prevent and treat
13 child abuse (including sexual abuse) among urban
14 Indians.
15 "(2) ASSESSMENT.—A grant may not be made
16 under this subsection to an urban Indian organiza-
17 tion until that organization has prepared, and the
18 Service has approved, an assessment that documents
19 the prevalence of child abuse in the urban Indian
20 population concerned and specifies the services and
21 programs (which may not duplicate existing services
22 and programs) for which the grant is requested.
23 "(3) USE OF FUNDS.—Grants may be made
24 under this subsection—

1 "(A) to prepare assessments required
2 under paragraph (2);
3 "(B) for the development of prevention,
4 training, and education programs for urban In-
5 dian populations, including child education, par-
6 ent education, provider training on identifica-
7 tion and intervention, education on reporting
8 requirements, prevention campaigns, and estab-
9 lishing service networks of all those involved in
10 Indian child protection; and
11 "(C) to provide direct outpatient treatment
12 services (including individual treatment, family
13 treatment, group therapy, and support groups)
14 to urban Indians who are child victims of abuse
15 (including sexual abuse) or adult survivors of
16 child sexual abuse, to the families of such child
17 victims, and to urban Indian perpetrators of
18 child abuse (including sexual abuse).
19 "(4) CONSIDERATIONS.—In making grants to
20 carry out this subsection, the Secretary shall take
21 into consideration—
22 "(A) the support for the urban Indian or-
23 ganization demonstrated by the child protection
24 authorities in the area, including committees or
25 other services funded under the Indian Child

1 Welfare Act of 1978 (25 U.S.C. 1901 et seq.),
2 if any;
3 "(B) the capability and expertise dem-
4 onstrated by the urban Indian organization to
5 address the complex problem of child sexual
6 abuse in the community; and
7 "(C) the assessment required under para-
8 graph (2).
9 "(g) MULTIPLE URBAN CENTERS.—The Secretary,
10 acting through the Service, may enter into a contract with,
11 or make grants to, an urban Indian organization that pro-
12 vides or arranges for the provision of health care services
13 (through satellite facilities, provider networks, or other-
14 wise) to urban Indians in more than one urban center.
15 **"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINA-**
16 **TION OF UNMET HEALTH CARE NEEDS.**
17 "(a) AUTHORITY.—
18 "(1) IN GENERAL.—Under authority of the Act
19 of November 2, 1921 (25 U.S.C. 13) (commonly
20 known as the Snyder Act), the Secretary, acting
21 through the Service, may enter into contracts with,
22 or make grants to, urban Indian organizations situ-
23 ated in urban centers for which contracts have not
24 been entered into, or grants have not been made,
25 under section 503.

1 "(2) PURPOSE.—The purpose of a contract or
2 grant made under this section shall be the deter-
3 mination of the matters described in subsection
4 (b)(1) in order to assist the Secretary in assessing
5 the health status and health care needs of urban In-
6 dians in the urban center involved and determining
7 whether the Secretary should enter into a contract
8 or make a grant under section 503 with respect to
9 the urban Indian organization which the Secretary
10 has entered into a contract with, or made a grant
11 to, under this section.
12 "(b) REQUIREMENTS.—Any contract entered into, or
13 grant made, by the Secretary under this section shall in-
14 clude requirements that—
15 "(1) the urban Indian organization successfully
16 undertake to—
17 "(A) document the health care status and
18 unmet health care needs of urban Indians in
19 the urban center involved; and
20 "(B) with respect to urban Indians in the
21 urban center involved, determine the matters
22 described in paragraphs (2), (3), (4), and (7) of
23 section 503(b); and
24 "(2) the urban Indian organization complete
25 performance of the contract, or carry out the re-

1 quirements of the grant, within 1 year after the date
2 on which the Secretary and such organization enter
3 into such contract, or within 1 year after such orga-
4 nization receives such grant, whichever is applicable.
5 "(c) LIMITATION ON RENEWAL.—The Secretary may
6 not renew any contract entered into, or grant made, under
7 this section.

8 **"SEC. 505. EVALUATIONS; RENEWALS.**

9 "(a) PROCEDURES.—The Secretary, acting through
10 the Service, shall develop procedures to evaluate compli-
11 ance with grant requirements under this title and compli-
12 ance with, and performance of contracts entered into by
13 urban Indian organizations under this title. Such proce-
14 dures shall include provisions for carrying out the require-
15 ments of this section.
16 "(b) COMPLIANCE WITH TERMS.—The Secretary,
17 acting through the Service, shall evaluate the compliance
18 of each urban Indian organization which has entered into
19 a contract or received a grant under section 503 with the
20 terms of such contract of grant. For purposes of an eval-
21 uation under this subsection, the Secretary, in determin-
22 ing the capacity of an urban Indian organization to deliver
23 quality patient care shall, at the option of the
24 organization—

1 "(1) conduct, through the Service, an annual
2 onsite evaluation of the organization; or
3 "(2) accept, in lieu of an onsite evaluation, evi-
4 dence of the organization's provisional or full accred-
5 itation by a private independent entity recognized by
6 the Secretary for purposes of conducting quality re-
7 views of providers participating in the medicare pro-
8 gram under Title XVIII of the Social Security Act.
9 "(c) NONCOMPLIANCE.—
10 "(1) IN GENERAL.—If, as a result of the eval-
11 uations conducted under this section, the Secretary
12 determines that an urban Indian organization has
13 not complied with the requirements of a grant or
14 complied with or satisfactorily performed a contract
15 under section 503, the Secretary shall, prior to re-
16 newing such contract or grant, attempt to resolve
17 with such organization the areas of noncompliance
18 or unsatisfactory performance and modify such con-
19 tract or grant to prevent future occurrences of such
20 noncompliance or unsatisfactory performance.
21 "(2) NONRENEWAL.—If the Secretary deter-
22 mines, under an evaluation under this section, that
23 noncompliance or unsatisfactory performance cannot
24 be resolved and prevented in the future, the Sec-
25 retary shall not renew such contract or grant with

1 such organization and is authorized to enter into a
2 contract or make a grant under section 503 with an-
3 other urban Indian organization which is situated in
4 the same urban center as the urban Indian organiza-
5 tion whose contract or grant is not renewed under
6 this section.

7 "(d) DETERMINATION OF RENEWAL.—In determin-
8 ing whether to renew a contract or grant with an urban
9 Indian organization under section 503 which has com-
10 pleted performance of a contract or grant under section
11 504, the Secretary shall review the records of the urban
12 Indian organization, the reports submitted under section
13 507, and, in the case of a renewal of a contract or grant
14 under section 503, shall consider the results of the onsite
15 evaluations or accreditation under subsection (b).

16 **"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.**

17 "(a) APPLICATION OF FEDERAL LAW.—Contracts
18 with urban Indian organizations entered into pursuant to
19 this title shall be in accordance with all Federal contract-
20 ing laws and regulations relating to procurement except
21 that, in the discretion of the Secretary, such contracts may
22 be negotiated without advertising and need not conform
23 to the provisions of the Act of August 24, 1935 (40 U.S.C.
24 270a, et seq.).

1 "(b) PAYMENTS.—Payments under any contracts or
2 grants pursuant to this title shall, notwithstanding any
3 term or condition of such contract or grant—
4 "(1) be made in their entirety by the Secretary
5 to the urban Indian organization by not later than
6 the end of the first 30 days of the funding period
7 with respect to which the payments apply, unless the
8 Secretary determines through an evaluation under
9 section 505 that the organization is not capable of
10 administering such payments in their entirety; and
11 "(2) if unexpended by the urban Indian organi-
12 zation during the funding period with respect to
13 which the payments initially apply, be carried for-
14 ward for expenditure with respect to allowable or re-
15 imbursable costs incurred by the organization during
16 1 or more subsequent funding periods without addi-
17 tional justification or documentation by the organi-
18 zation as a condition of carrying forward the ex-
19 penditure of such funds.
20 "(c) REVISING OR AMENDING CONTRACT.—Notwith-
21 standing any provision of law to the contrary, the Sec-
22 retary may, at the request or consent of an urban Indian
23 organization, revise or amend any contract entered into
24 by the Secretary with such organization under this title
25 as necessary to carry out the purposes of this title.

1 "(d) FAIR AND UNIFORM PROVISION OF SERV-
2 ICES.—Contracts with, or grants to, urban Indian organi-
3 zations and regulations adopted pursuant to this title shall
4 include provisions to assure the fair and uniform provision
5 to urban Indians of services and assistance under such
6 contracts or grants by such organizations.

7 "(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indi-
8 ans, as defined in section 4(f), shall be eligible for health
9 care or referral services provided pursuant to this title.

10 **"SEC. 507. REPORTS AND RECORDS.**

11 "(a) REPORT.—For each fiscal year during which an
12 urban Indian organization receives or expends funds pur-
13 suant to a contract entered into, or a grant received, pur-
14 suant to this title, such organization shall submit to the
15 Secretary, on a basis no more frequent than every 6
16 months, a report including—

17 "(1) in the case of a contract or grant under
18 section 503, information gathered pursuant to para-
19 graph (5) of subsection (a) of such section;

20 "(2) information on activities conducted by the
21 organization pursuant to the contract or grant;

22 "(3) an accounting of the amounts and pur-
23 poses for which Federal funds were expended; and

24 "(4) a minimum set of data, using uniformly
25 defined elements, that is specified by the Secretary,

1 after consultations consistent with section 514, with
2 urban Indian organizations.
3 "(b) AUDITS.—The reports and records of the urban
4 Indian organization with respect to a contract or grant
5 under this title shall be subject to audit by the Secretary
6 and the Comptroller General of the United States.
7 "(c) COST OF AUDIT.—The Secretary shall allow as
8 a cost of any contract or grant entered into or awarded
9 under section 502 or 503 the cost of an annual independ-
10 ent financial audit conducted by—
11 "(1) a certified public accountant; or
12 "(2) a certified public accounting firm qualified
13 to conduct Federal compliance audits.
14 **"SEC. 508. LIMITATION ON CONTRACT AUTHORITY.**
15 "The authority of the Secretary to enter into con-
16 tracts or to award grants under this title shall be to the
17 extent, and in an amount, provided for in appropriation
18 Acts.
19 **"SEC. 509. FACILITIES.**
20 "(a) GRANTS.—The Secretary may make grants to
21 contractors or grant recipients under this title for the
22 lease, purchase, renovation, construction, or expansion of
23 facilities, including leased facilities, in order to assist such
24 contractors or grant recipients in complying with applica-
25 ble licensure or certification requirements.

1 "(b) LOANS OR LOAN GUARANTEES.—The Secretary,
2 acting through the Service or through the Health Re-
3 sources and Services Administration, may provide loans
4 to contractors or grant recipients under this title from the
5 Urban Indian Health Care Facilities Revolving Loan
6 Fund (referred to in this section as the 'URLF') described
7 in subsection (c), or guarantees for loans, for the construc-
8 tion, renovation, expansion, or purchase of health care fa-
9 cilities, subject to the following requirements:

10 "(1) The principal amount of a loan or loan
11 guarantee may cover 100 percent of the costs (other
12 than staffing) relating to the facility, including plan-
13 ning, design, financing, site land development, con-
14 struction, rehabilitation, renovation, conversion,
15 medical equipment, furnishings, and capital pur-
16 chase.

17 "(2) The total amount of the principal of loans
18 and loan guarantees, respectively, outstanding at
19 any one time shall not exceed such limitations as
20 may be specified in appropriations Acts.

21 "(3) The loan or loan guarantee may have a
22 term of the shorter of the estimated useful life of the
23 facility, or 25 years.

24 "(4) An urban Indian organization may assign,
25 and the Secretary may accept assignment of, the

1 revenue of the organization as security for a loan or
2 loan guarantee under this subsection.
3 "(5) The Secretary shall not collect application,
4 processing, or similar fees from urban Indian organi-
5 zations applying for loans or loan guarantees under
6 this subsection.
7 "(c) URBAN INDIAN HEALTH CARE FACILITIES RE-
8 VOLVING LOAN FUND.—
9 "(1) ESTABLISHMENT.—There is established in
10 the Treasury of the United States a fund to be
11 known as the Urban Indian Health Care Facilities
12 Revolving Loan Fund. The URLF shall consist of—
13 "(A) such amounts as may be appropriated
14 to the URLF;
15 "(B) amounts received from urban Indian
16 organizations in repayment of loans made to
17 such organizations under paragraph (2); and
18 "(C) interest earned on amounts in the
19 URLF under paragraph (3).
20 "(2) USE OF URLF.—Amounts in the URLF
21 may be expended by the Secretary, acting through
22 the Service or the Health Resources and Services
23 Administration, to make loans available to urban In-
24 dian organizations receiving grants or contracts
25 under this title for the purposes, and subject to the

1 requirements, described in subsection (b). Amounts
2 appropriated to the URLF, amounts received from
3 urban Indian organizations in repayment of loans,
4 and interest on amounts in the URLF shall remain
5 available until expended.

6 "(3) INVESTMENTS.—The Secretary of the
7 Treasury shall invest such amounts of the URLF as
8 such Secretary determines are not required to meet
9 current withdrawals from the URLF. Such invest-
10 ments may be made only in interest-bearing obliga-
11 tions of the United States. For such purpose, such
12 obligations may be acquired on original issue at the
13 issue price, or by purchase of outstanding obliga-
14 tions at the market price. Any obligation acquired by
15 the URLF may be sold by the Secretary of the
16 Treasury at the market price.

17 **"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.**

18 "There is hereby established within the Service an
19 Office of Urban Indian Health which shall be responsible
20 for—

21 "(1) carrying out the provisions of this title;

22 "(2) providing central oversight of the pro-
23 grams and services authorized under this title; and

24 "(3) providing technical assistance to urban In-
25 dian organizations.

1 **"SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE**
2 **RELATED SERVICES.**

3 "(a) GRANTS.—The Secretary may make grants for
4 the provision of health-related services in prevention of,
5 treatment of, rehabilitation of, or school and community-
6 based education in, alcohol and substance abuse in urban
7 centers to those urban Indian organizations with whom
8 the Secretary has entered into a contract under this title
9 or under section 201.

10 "(b) GOALS OF GRANT.—Each grant made pursuant
11 to subsection (a) shall set forth the goals to be accom-
12 plished pursuant to the grant. The goals shall be specific
13 to each grant as agreed to between the Secretary and the
14 grantee.

15 "(c) CRITERIA.—The Secretary shall establish cri-
16 teria for the grants made under subsection (a), including
17 criteria relating to the—

18 "(1) size of the urban Indian population;

19 "(2) capability of the organization to adequately
20 perform the activities required under the grant;

21 "(3) satisfactory performance standards for the
22 organization in meeting the goals set forth in such
23 grant, which standards shall be negotiated and
24 agreed to between the Secretary and the grantee on
25 a grant-by-grant basis; and

26 "(4) identification of need for services.

1 The Secretary shall develop a methodology for allocating
2 grants made pursuant to this section based on such cri-
3 teria.

4 "(d) TREATMENT OF FUNDS RECEIVED BY URBAN
5 INDIAN ORGANIZATIONS.—Any funds received by an
6 urban Indian organization under this Act for substance
7 abuse prevention, treatment, and rehabilitation shall be
8 subject to the criteria set forth in subsection (c).

9 **"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION**
10 **PROJECTS.**

11 "(a) OKLAHOMA CITY CLINIC.—

12 "(1) IN GENERAL.—Notwithstanding any other
13 provision of law, the Oklahoma City Clinic dem-
14 onstration project shall be treated as a service unit
15 in the allocation of resources and coordination of
16 care and shall not be subject to the provisions of the
17 Indian Self-Determination and Education Assistance
18 Act for the term of such projects. The Secretary
19 shall provide assistance to such projects in the devel-
20 opment of resources and equipment and facility
21 needs.

22 "(2) REPORT.—The Secretary shall submit to
23 the President, for inclusion in the report required to
24 be submitted to the Congress under section 801 for
25 fiscal year 1999, a report on the findings and con-

1 clusions derived from the demonstration project
2 specified in paragraph (1).
3 "(b) TULSA CLINIC.—Notwithstanding any other
4 provision of law, the Tulsa Clinic demonstration project
5 shall become a permanent program within the Service's
6 direct care program and continue to be treated as a service
7 unit in the allocation of resources and coordination of
8 care, and shall continue to meet the requirements and
9 definitions of an urban Indian organization in this title,
10 and as such will not be subject to the provisions of the
11 Indian Self-Determination and Education Assistance Act.
12 **"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.**
13 "(a) GRANTS AND CONTRACTS.—The Secretary, act-
14 ing through the Office of Urban Indian Health of the
15 Service, shall make grants or enter into contracts, effective
16 not later than September 30, 2001, with urban Indian or-
17 ganizations for the administration of urban Indian alcohol
18 programs that were originally established under the Na-
19 tional Institute on Alcoholism and Alcohol Abuse (referred
20 to in this section to as 'NIAAA') and transferred to the
21 Service.
22 "(b) USE OF FUNDS.—Grants provided or contracts
23 entered into under this section shall be used to provide
24 support for the continuation of alcohol prevention and
25 treatment services for urban Indian populations and such

1 other objectives as are agreed upon between the Service
2 and a recipient of a grant or contract under this section.
3 "(c) ELIGIBILITY.—Urban Indian organizations that
4 operate Indian alcohol programs originally funded under
5 NIAAA and subsequently transferred to the Service are
6 eligible for grants or contracts under this section.
7 "(d) EVALUATION AND REPORT.—The Secretary
8 shall evaluate and report to the Congress on the activities
9 of programs funded under this section at least every 5
10 years.

11 **"SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZA-**
12 **TIONS.**

13 "(a) IN GENERAL.—The Secretary shall ensure that
14 the Service, the Health Care Financing Administration,
15 and other operating divisions and staff divisions of the De-
16 partment consult, to the maximum extent practicable, with
17 urban Indian organizations (as defined in section 4) prior
18 to taking any action, or approving Federal financial assist-
19 ance for any action of a State, that may affect urban Indi-
20 ans or urban Indian organizations.
21 "(b) REQUIREMENT.—In subsection (a), the term
22 'consultation' means the open and free exchange of infor-
23 mation and opinion among urban Indian organizations
24 and the operating and staff divisions of the Department
25 which leads to mutual understanding and comprehension

1 and which emphasizes trust, respect, and shared respon-
2 sibility.

3 **"SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.**

4 "For purposes of section 224 of the Public Health
5 Service Act (42 U.S.C. 233), with respect to claims by
6 any person, initially filed on or after October 1, 1999,
7 whether or not such person is an Indian or Alaska Native
8 or is served on a fee basis or under other circumstances
9 as permitted by Federal law or regulations, for personal
10 injury (including death) resulting from the performance
11 prior to, including, or after October 1, 1999, of medical,
12 surgical, dental, or related functions, including the con-
13 duct of clinical studies or investigations, or for purposes
14 of section 2679 of title 28, United States Code, with re-
15 spect to claims by any such person, on or after October
16 1, 1999, for personal injury (including death) resulting
17 from the operation of an emergency motor vehicle, an
18 urban Indian organization that has entered into a contract
19 or received a grant pursuant to this title is deemed to be
20 part of the Public Health Service while carrying out any
21 such contract or grant and its employees (including those
22 acting on behalf of the organization as provided for in sec-
23 tion 2671 of title 28, United States Code, and including
24 an individual who provides health care services pursuant
25 to a personal services contract with an urban Indian orga-

1 nization for the provision of services in any facility owned,
2 operated, or constructed under the jurisdiction of the In-
3 dian Health Service) are deemed employees of the Service
4 while acting within the scope of their employment in carry-
5 ing out the contract or grant, except that such employees
6 shall be deemed to be acting within the scope of their em-
7 ployment in carrying out the contract or grant when they
8 are required, by reason of their employment, to perform
9 medical, surgical, dental or related functions at a facility
10 other than a facility operated by the urban Indian organi-
11 zation pursuant to such contract or grant, but only if such
12 employees are not compensated for the performance of
13 such functions by a person or entity other than the urban
14 Indian organization.

15 **"SEC. 516. URBAN YOUTH TREATMENT CENTER DEM-**
16 **ONSTRATION.**

17 "(a) CONSTRUCTION AND OPERATION.—The Sec-
18 retary, acting through the Service, shall, through grants
19 or contracts, make payment for the construction and oper-
20 ation of at least 2 residential treatment centers in each
21 State described in subsection (b) to demonstrate the provi-
22 sion of alcohol and substance abuse treatment services to
23 urban Indian youth in a culturally competent residential
24 setting.

1 "(b) STATES.—A State described in this subsection
2 is a State in which—
3 "(1) there reside urban Indian youth with a
4 need for alcohol and substance abuse treatment serv-
5 ices in a residential setting; and
6 "(2) there is a significant shortage of culturally
7 competent residential treatment services for urban
8 Indian youth.

9 **"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND**
10 **SOURCES OF SUPPLY.**

11 "(a) IN GENERAL.—The Secretary shall permit an
12 urban Indian organization that has entered into a contract
13 or received a grant pursuant to this title, in carrying out
14 such contract or grant, to use existing facilities and all
15 equipment therein or pertaining thereto and other per-
16 sonal property owned by the Federal Government within
17 the Secretary's jurisdiction under such terms and condi-
18 tions as may be agreed upon for their use and mainte-
19 nance.
20 "(b) DONATION OF PROPERTY.—Subject to sub-
21 section (d), the Secretary may donate to an urban Indian
22 organization that has entered into a contract or received
23 a grant pursuant to this title any personal or real property
24 determined to be excess to the needs of the Service or the

1 General Services Administration for purposes of carrying
2 out the contract or grant.
3 "(c) ACQUISITION OF PROPERTY.—The Secretary
4 may acquire excess or surplus government personal or real
5 property for donation, subject to subsection (d), to an
6 urban Indian organization that has entered into a contract
7 or received a grant pursuant to this title if the Secretary
8 determines that the property is appropriate for use by the
9 urban Indian organization for a purpose for which a con-
10 tract or grant is authorized under this title.
11 "(d) PRIORITY.—In the event that the Secretary re-
12 ceives a request for a specific item of personal or real
13 property described in subsections (b) or (c) from an urban
14 Indian organization and from an Indian tribe or tribal or-
15 ganization, the Secretary shall give priority to the request
16 for donation to the Indian tribe or tribal organization if
17 the Secretary receives the request from the Indian tribe
18 or tribal organization before the date on which the Sec-
19 retary transfers title to the property or, if earlier, the date
20 on which the Secretary transfers the property physically,
21 to the urban Indian organization.
22 "(e) RELATION TO FEDERAL SOURCES OF SUP-
23 PLY.—For purposes of section 201(a) of the Federal
24 Property and Administrative Services Act of 1949 (40
25 U.S.C. 481(a)) (relating to Federal sources of supply, in-

1 cluding lodging providers, airlines, and other transpor-
2 tation providers), an urban Indian organization that has
3 entered into a contract or received a grant pursuant to
4 this title shall be deemed an executive agency when carry-
5 ing out such contract or grant, and the employees of the
6 urban Indian organization shall be eligible to have access
7 to such sources of supply on the same basis as employees
8 of an executive agency have such access.

9 **"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREAT-**
10 **MENT AND CONTROL.**

11 "(a) AUTHORITY.—The Secretary may make grants
12 to those urban Indian organizations that have entered into
13 a contract or have received a grant under this title for
14 the provision of services for the prevention, treatment, and
15 control of the complications resulting from, diabetes
16 among urban Indians.

17 "(b) GOALS.—Each grant made pursuant to sub-
18 section (a) shall set forth the goals to be accomplished
19 under the grant. The goals shall be specific to each grant
20 as agreed upon between the Secretary and the grantee.

21 "(c) CRITERIA.—The Secretary shall establish cri-
22 teria for the awarding of grants made under subsection
23 (a) relating to—

24 "(1) the size and location of the urban Indian
25 population to be served;

1 "(2) the need for the prevention of, treatment
2 of, and control of the complications resulting from
3 diabetes among the urban Indian population to be
4 served;
5 "(3) performance standards for the urban In-
6 dian organization in meeting the goals set forth in
7 such grant that are negotiated and agreed to by the
8 Secretary and the grantee;
9 "(4) the capability of the urban Indian organi-
10 zation to adequately perform the activities required
11 under the grant; and
12 "(5) the willingness of the urban Indian organi-
13 zation to collaborate with the registry, if any, estab-
14 lished by the Secretary under section 204(e) in the
15 area office of the Service in which the organization
16 is located.
17 "(d) APPLICATION OF CRITERIA.—Any funds re-
18 ceived by an urban Indian organization under this Act for
19 the prevention, treatment, and control of diabetes among
20 urban Indians shall be subject to the criteria developed
21 by the Secretary under subsection (c).
22 **"SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.**
23 "The Secretary, acting through the Service, may
24 enter into contracts with, and make grants to, urban In-
25 dian organizations for the use of Indians trained as health

1 service providers through the Community Health Rep-
2 resentatives Program under section 107(b) in the provi-
3 sion of health care, health promotion, and disease preven-
4 tion services to urban Indians.

5 **"SEC. 520. REGULATIONS.**

6 "(a) EFFECT OF TITLE.—This title shall be effective
7 on the date of enactment of this Act regardless of whether
8 the Secretary has promulgated regulations implementing
9 this title.

10 "(b) PROMULGATION.—

11 "(1) IN GENERAL.—The Secretary may promul-
12 gate regulations to implement the provisions of this
13 title.

14 "(2) PUBLICATION.—Proposed regulations to
15 implement this title shall be published by the Sec-
16 retary in the Federal Register not later than 270
17 days after the date of enactment of this Act and
18 shall have a comment period of not less than 120
19 days.

20 "(3) EXPIRATION OF AUTHORITY.—The author-
21 ity to promulgate regulations under this title shall
22 expire on the date that is 18 months after the date
23 of enactment of this Act.

24 "(c) NEGOTIATED RULEMAKING COMMITTEE.—A ne-
25 gotiated rulemaking committee shall be established pursu-

1 ant to section 565 of title 5, United States Code, to carry
2 out this section and shall, in addition to Federal represent-
3 atives, have as the majority of its members representatives
4 of urban Indian organizations from each service area.

5 "(d) ADAPTION OF PROCEDURES.—The Secretary
6 shall adapt the negotiated rulemaking procedures to the
7 unique context of this Act.

8 **"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.**

9 "There is authorized to be appropriated such sums
10 as may be necessary for each fiscal year through fiscal
11 year 2012 to carry out this title.

12 "TITLE VI—ORGANIZATIONAL 13 IMPROVEMENTS

14 **"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
15 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
16 **SERVICE.**

17 "(a) ESTABLISHMENT.—

18 "(1) IN GENERAL.—In order to more effectively
19 and efficiently carry out the responsibilities, authori-
20 ties, and functions of the United States to provide
21 health care services to Indians and Indian tribes, as
22 are or may be hereafter provided by Federal statute
23 or treaties, there is established within the Public
24 Health Service of the Department the Indian Health
25 Service.

1 "(2) ASSISTANT SECRETARY OF INDIAN
2 HEALTH.—The Service shall be administered by an
3 Assistance Secretary of Indian Health, who shall be
4 appointed by the President, by and with the advice
5 and consent of the Senate. The Assistant Secretary
6 shall report to the Secretary. Effective with respect
7 to an individual appointed by the President, by and
8 with the advice and consent of the Senate, after
9 January 1, 1993, the term of service of the Assist-
10 ant Secretary shall be 4 years. An Assistant Sec-
11 retary may serve more than 1 term.
12 "(b) AGENCY.—The Service shall be an agency within
13 the Public Health Service of the Department, and shall
14 not be an office, component, or unit of any other agency
15 of the Department.
16 "(c) FUNCTIONS AND DUTIES.—The Secretary shall
17 carry out through the Assistant Secretary of the Service—
18 "(1) all functions which were, on the day before
19 the date of enactment of the Indian Health Care
20 Amendments of 1988, carried out by or under the
21 direction of the individual serving as Director of the
22 Service on such day;
23 "(2) all functions of the Secretary relating to
24 the maintenance and operation of hospital and
25 health facilities for Indians and the planning for,

1 and provision and utilization of, health services for
2 Indians;
3 "(3) all health programs under which health
4 care is provided to Indians based upon their status
5 as Indians which are administered by the Secretary,
6 including programs under—
7 "(A) this Act;
8 "(B) the Act of November 2, 1921 (25
9 U.S.C. 13);
10 "(C) the Act of August 5, 1954 (42 U.S.C.
11 2001, et seq.);
12 "(D) the Act of August 16, 1957 (42
13 U.S.C. 2005 et seq.); and
14 "(E) the Indian Self-Determination Act
15 (25 U.S.C. 450f, et seq.); and
16 "(4) all scholarship and loan functions carried
17 out under title I.
18 "(d) AUTHORITY.—
19 "(1) IN GENERAL.—The Secretary, acting
20 through the Assistant Secretary, shall have the
21 authority—
22 "(A) except to the extent provided for in
23 paragraph (2), to appoint and compensate em-
24 ployees for the Service in accordance with title
25 5, United States Code;

1 "(B) to enter into contracts for the pro-
2 curement of goods and services to carry out the
3 functions of the Service; and
4 "(C) to manage, expend, and obligate all
5 funds appropriated for the Service.
6 "(2) PERSONNEL ACTIONS.—Notwithstanding
7 any other provision of law, the provisions of section
8 12 of the Act of June 18, 1934 (48 Stat. 986; 25
9 U.S.C. 472), shall apply to all personnel actions
10 taken with respect to new positions created within
11 the Service as a result of its establishment under
12 subsection (a).

13 **"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYS-**
14 **TEM.**

15 "(a) ESTABLISHMENT.—
16 "(1) IN GENERAL.—The Secretary, in consulta-
17 tion with tribes, tribal organizations, and urban In-
18 dian organizations, shall establish an automated
19 management information system for the Service.
20 "(2) REQUIREMENTS OF SYSTEM.—The infor-
21 mation system established under paragraph (1) shall
22 include—
23 "(A) a financial management system;
24 "(B) a patient care information system;

1 "(C) a privacy component that protects the
2 privacy of patient information;
3 "(D) a services-based cost accounting com-
4 ponent that provides estimates of the costs as-
5 sociated with the provision of specific medical
6 treatments or services in each area office of the
7 Service;
8 "(E) an interface mechanism for patient
9 billing and accounts receivable system; and
10 "(F) a training component.
11 "(b) PROVISION OF SYSTEMS TO TRIBES AND ORGA-
12 NIZATIONS.—The Secretary shall provide each Indian
13 tribe and tribal organization that provides health services
14 under a contract entered into with the Service under the
15 Indian Self-Determination Act automated management in-
16 formation systems which—
17 "(1) meet the management information needs
18 of such Indian tribe or tribal organization with re-
19 spect to the treatment by the Indian tribe or tribal
20 organization of patients of the Service; and
21 "(2) meet the management information needs
22 of the Service.
23 "(c) ACCESS TO RECORDS.—Notwithstanding any
24 other provision of law, each patient shall have reasonable

1 access to the medical or health records of such patient
2 which are held by, or on behalf of, the Service.
3 "(d) AUTHORITY TO ENHANCE INFORMATION TECH-
4 NOLOGY.—The Secretary, acting through the Assistant
5 Secretary, shall have the authority to enter into contracts,
6 agreements or joint ventures with other Federal agencies,
7 States, private and nonprofit organizations, for the pur-
8 pose of enhancing information technology in Indian health
9 programs and facilities.

10 **"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.**

11 "There is authorized to be appropriated such sums
12 as may be necessary for each fiscal year through fiscal
13 year 2012 to carry out this title.

14 "TITLE VII—BEHAVIORAL
15 HEALTH PROGRAMS

16 **"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREAT-**
17 **MENT SERVICES.**

18 "(a) PURPOSES.—It is the purpose of this section
19 to—
20 "(1) authorize and direct the Secretary, acting
21 through the Service, Indian tribes, tribal organiza-
22 tions, and urban Indian organizations to develop a
23 comprehensive behavioral health prevention and
24 treatment program which emphasizes collaboration

1 among alcohol and substance abuse, social services,
2 and mental health programs;
3 "(2) provide information, direction and guid-
4 ance relating to mental illness and dysfunction and
5 self-destructive behavior, including child abuse and
6 family violence, to those Federal, tribal, State and
7 local agencies responsible for programs in Indian
8 communities in areas of health care, education, so-
9 cial services, child and family welfare, alcohol and
10 substance abuse, law enforcement and judicial serv-
11 ices;
12 "(3) assist Indian tribes to identify services and
13 resources available to address mental illness and
14 dysfunctional and self-destructive behavior;
15 "(4) provide authority and opportunities for In-
16 dian tribes to develop and implement, and coordinate
17 with, community-based programs which include iden-
18 tification, prevention, education, referral, and treat-
19 ment services, including through multi-disciplinary
20 resource teams;
21 "(5) ensure that Indians, as citizens of the
22 United States and of the States in which they re-
23 side, have the same access to behavioral health serv-
24 ices to which all citizens have access; and

1 "(6) modify or supplement existing programs
2 and authorities in the areas identified in paragraph
3 (2).
4 "(b) BEHAVIORAL HEALTH PLANNING.—
5 "(1) AREA-WIDE PLANS.—The Secretary, acting
6 through the Service, Indian tribes, tribal organiza-
7 tions, and urban Indian organizations, shall encour-
8 age Indian tribes and tribal organizations to develop
9 tribal plans, encourage urban Indian organizations
10 to develop local plans, and encourage all such groups
11 to participate in developing area-wide plans for In-
12 dian Behavioral Health Services. The plans shall, to
13 the extent feasible, include—
14 "(A) an assessment of the scope of the
15 problem of alcohol or other substance abuse,
16 mental illness, dysfunctional and self-destruc-
17 tive behavior, including suicide, child abuse and
18 family violence, among Indians, including—
19 "(i) the number of Indians served who
20 are directly or indirectly affected by such
21 illness or behavior; and
22 "(ii) an estimate of the financial and
23 human cost attributable to such illness or
24 behavior;

1 "(B) an assessment of the existing and ad-
2 ditional resources necessary for the prevention
3 and treatment of such illness and behavior, in-
4 cluding an assessment of the progress toward
5 achieving the availability of the full continuum
6 of care described in subsection (c); and
7 "(C) an estimate of the additional funding
8 needed by the Service, Indian tribes, tribal or-
9 ganizations and urban Indian organizations to
10 meet their responsibilities under the plans.
11 "(2) NATIONAL CLEARINGHOUSE.—The Sec-
12 retary shall establish a national clearinghouse of
13 plans and reports on the outcomes of such plans de-
14 veloped under this section by Indian tribes, tribal or-
15 ganizations and by areas relating to behavioral
16 health. The Secretary shall ensure access to such
17 plans and outcomes by any Indian tribe, tribal orga-
18 nization, urban Indian organization or the Service.
19 "(3) TECHNICAL ASSISTANCE.—The Secretary
20 shall provide technical assistance to Indian tribes,
21 tribal organizations, and urban Indian organizations
22 in preparation of plans under this section and in de-
23 veloping standards of care that may be utilized and
24 adopted locally.

1 "(c) CONTINUUM OF CARE.—The Secretary, acting
2 through the Service, Indian tribes and tribal organiza-
3 tions, shall provide, to the extent feasible and to the extent
4 that funding is available, for the implementation of pro-
5 grams including—
6 "(1) a comprehensive continuum of behavioral
7 health care that provides for—
8 "(A) community based prevention, inter-
9 vention, outpatient and behavioral health
10 aftercare;
11 "(B) detoxification (social and medical);
12 "(C) acute hospitalization;
13 "(D) intensive outpatient or day treat-
14 ment;
15 "(E) residential treatment;
16 "(F) transitional living for those needing a
17 temporary stable living environment that is sup-
18 portive of treatment or recovery goals;
19 "(G) emergency shelter;
20 "(H) intensive case management; and
21 "(I) traditional health care practices; and
22 "(2) behavioral health services for particular
23 populations, including—

1 "(A) for persons from birth through age
2 17, child behavioral health services, that
3 include—
4 "(i) pre-school and school age fetal al-
5 cohol disorder services, including assess-
6 ment and behavioral intervention);
7 "(ii) mental health or substance abuse
8 services (emotional, organic, alcohol, drug,
9 inhalant and tobacco);
10 "(iii) services for co-occurring dis-
11 orders (multiple diagnosis);
12 "(iv) prevention services that are fo-
13 cused on individuals ages 5 years through
14 10 years (alcohol, drug, inhalant and to-
15 bacco);
16 "(v) early intervention, treatment and
17 aftercare services that are focused on indi-
18 viduals ages 11 years through 17 years;
19 "(vi) healthy choices or life style serv-
20 ices (related to STD's, domestic violence,
21 sexual abuse, suicide, teen pregnancy, obe-
22 sity, and other risk or safety issues);
23 "(vii) co-morbidity services;

1 "(B) for persons ages 18 years through 55
2 years, adult behavioral health services that
3 include—
4 "(i) early intervention, treatment and
5 aftercare services;
6 "(ii) mental health and substance
7 abuse services (emotional, alcohol, drug,
8 inhalant and tobacco);
9 "(iii) services for co-occurring dis-
10 orders (dual diagnosis) and co-morbidity;
11 "(iv) healthy choices and life style
12 services (related to parenting, partners, do-
13 mestic violence, sexual abuse, suicide, obe-
14 sity, and other risk related behavior);
15 "(v) female specific treatment services
16 for—
17 "(I) women at risk of giving
18 birth to a child with a fetal alcohol
19 disorder;
20 "(II) substance abuse requiring
21 gender specific services;
22 "(III) sexual assault and domes-
23 tic violence; and
24 "(IV) healthy choices and life
25 style (parenting, partners, obesity,

1 suicide and other related behavioral
2 risk); and
3 "(vi) male specific treatment services
4 for—
5 "(I) substance abuse requiring
6 gender specific services;
7 "(II) sexual assault and domestic
8 violence; and
9 "(III) healthy choices and life
10 style (parenting, partners, obesity,
11 suicide and other risk related behav-
12 ior);
13 "(C) family behavioral health services,
14 including—
15 "(i) early intervention, treatment and
16 aftercare for affected families;
17 "(ii) treatment for sexual assault and
18 domestic violence; and
19 "(iii) healthy choices and life style (re-
20 lated to parenting, partners, domestic vio-
21 lence and other abuse issues);
22 "(D) for persons age 56 years and older,
23 elder behavioral health services including—
24 "(i) early intervention, treatment and
25 aftercare services that include—

1 "(I) mental health and substance
2 abuse services (emotional, alcohol,
3 drug, inhalant and tobacco);
4 "(II) services for co-occurring
5 disorders (dual diagnosis) and co-mor-
6 bidity; and
7 "(III) healthy choices and life
8 style services (managing conditions re-
9 lated to aging);
10 "(ii) elder women specific services
11 that include—
12 "(I) treatment for substance
13 abuse requiring gender specific serv-
14 ices and
15 "(II) treatment for sexual as-
16 sault, domestic violence and neglect;
17 "(iii) elder men specific services that
18 include—
19 "(I) treatment for substance
20 abuse requiring gender specific serv-
21 ices; and
22 "(II) treatment for sexual as-
23 sault, domestic violence and neglect;
24 and

1 "(iv) services for dementia regardless
2 of cause.
3 "(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—
4 "(1) IN GENERAL.—The governing body of any
5 Indian tribe or tribal organization or urban Indian
6 organization may, at its discretion, adopt a resolu-
7 tion for the establishment of a community behavioral
8 health plan providing for the identification and co-
9 ordination of available resources and programs to
10 identify, prevent, or treat alcohol and other sub-
11 stance abuse, mental illness or dysfunctional and
12 self-destructive behavior, including child abuse and
13 family violence, among its members or its service
14 population. Such plan should include behavioral
15 health services, social services, intensive outpatient
16 services, and continuing after care.
17 "(2) TECHNICAL ASSISTANCE.—In furtherance
18 of a plan established pursuant to paragraph (1) and
19 at the request of a tribe, the appropriate agency,
20 service unit, or other officials of the Bureau of In-
21 dian Affairs and the Service shall cooperate with,
22 and provide technical assistance to, the Indian tribe
23 or tribal organization in the development of a plan
24 under paragraph (1). Upon the establishment of
25 such a plan and at the request of the Indian tribe

1 or tribal organization, such officials shall cooperate
2 with the Indian tribe or tribal organization in the
3 implementation of such plan.
4 "(3) FUNDING.—The Secretary, acting through
5 the Service, may make funding available to Indian
6 tribes and tribal organizations adopting a resolution
7 pursuant to paragraph (1) to obtain technical assist-
8 ance for the development of a community behavioral
9 health plan and to provide administrative support in
10 the implementation of such plan.
11 "(e) COORDINATED PLANNING.—The Secretary, act-
12 ing through the Service, Indian tribes, tribal organiza-
13 tions, and urban Indian organizations shall coordinate be-
14 havioral health planning, to the extent feasible, with other
15 Federal and State agencies, to ensure that comprehensive
16 behavioral health services are available to Indians without
17 regard to their place of residence.
18 "(f) FACILITIES ASSESSMENT.—Not later than 1
19 year after the date of enactment of this Act, the Secretary,
20 acting through the Service, shall make an assessment of
21 the need for inpatient mental health care among Indians
22 and the availability and cost of inpatient mental health
23 facilities which can meet such need. In making such as-
24 sessment, the Secretary shall consider the possible conver-

1 sion of existing, under-utilized service hospital beds into
2 psychiatric units to meet such need.

3 **"SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DE-**
4 **PARTMENT OF THE INTERIOR.**

5 "(a) IN GENERAL.—Not later than 1 year after the
6 date of enactment of this Act, the Secretary and the Sec-
7 retary of the Interior shall develop and enter into a memo-
8 randum of agreement, or review and update any existing
9 memoranda of agreement as required under section 4205
10 of the Indian Alcohol and Substance Abuse Prevention
11 and Treatment Act of 1986 (25 U.S.C. 2411), and under
12 which the Secretaries address—

13 "(1) the scope and nature of mental illness and
14 dysfunctional and self-destructive behavior, including
15 child abuse and family violence, among Indians;

16 "(2) the existing Federal, tribal, State, local,
17 and private services, resources, and programs avail-
18 able to provide mental health services for Indians;

19 "(3) the unmet need for additional services, re-
20 sources, and programs necessary to meet the needs
21 identified pursuant to paragraph (1);

22 "(4)(A) the right of Indians, as citizens of the
23 United States and of the States in which they re-
24 side, to have access to mental health services to
25 which all citizens have access;

1 "(B) the right of Indians to participate in, and
2 receive the benefit of, such services; and
3 "(C) the actions necessary to protect the exer-
4 cise of such right;
5 "(5) the responsibilities of the Bureau of Indian
6 Affairs and the Service, including mental health
7 identification, prevention, education, referral, and
8 treatment services (including services through multi-
9 disciplinary resource teams), at the central, area,
10 and agency and service unit levels to address the
11 problems identified in paragraph (1);
12 "(6) a strategy for the comprehensive coordina-
13 tion of the mental health services provided by the
14 Bureau of Indian Affairs and the Service to meet
15 the needs identified pursuant to paragraph (1),
16 including—
17 "(A) the coordination of alcohol and sub-
18 stance abuse programs of the Service, the Bu-
19 reau of Indian Affairs, and the various Indian
20 tribes (developed under the Indian Alcohol and
21 Substance Abuse Prevention and Treatment
22 Act of 1986) with the mental health initiatives
23 pursuant to this Act, particularly with respect
24 to the referral and treatment of dually-diag-

1 nosed individuals requiring mental health and
2 substance abuse treatment; and
3 "(B) ensuring that Bureau of Indian Af-
4 fairs and Service programs and services (includ-
5 ing multidisciplinary resource teams) address-
6 ing child abuse and family violence are coordi-
7 nated with such non-Federal programs and
8 services;
9 "(7) direct appropriate officials of the Bureau
10 of Indian Affairs and the Service, particularly at the
11 agency and service unit levels, to cooperate fully
12 with tribal requests made pursuant to community
13 behavioral health plans adopted under section 701(c)
14 and section 4206 of the Indian Alcohol and Sub-
15 stance Abuse Prevention and Treatment Act of 1986
16 (25 U.S.C. 2412); and
17 "(8) provide for an annual review of such
18 agreement by the 2 Secretaries and a report which
19 shall be submitted to Congress and made available
20 to the Indian tribes.
21 "(b) SPECIFIC PROVISIONS.—The memorandum of
22 agreement updated or entered into pursuant to subsection
23 (a) shall include specific provisions pursuant to which the
24 Service shall assume responsibility for—

1 "(1) the determination of the scope of the prob-
2 lem of alcohol and substance abuse among Indian
3 people, including the number of Indians within the
4 jurisdiction of the Service who are directly or indi-
5 rectly affected by alcohol and substance abuse and
6 the financial and human cost;
7 "(2) an assessment of the existing and needed
8 resources necessary for the prevention of alcohol and
9 substance abuse and the treatment of Indians af-
10 fected by alcohol and substance abuse; and
11 "(3) an estimate of the funding necessary to
12 adequately support a program of prevention of alco-
13 hol and substance abuse and treatment of Indians
14 affected by alcohol and substance abuse.
15 "(c) CONSULTATION.—The Secretary and the Sec-
16 retary of the Interior shall, in developing the memoran-
17 dum of agreement under subsection (a), consult with and
18 solicit the comments of—
19 "(1) Indian tribes and tribal organizations;
20 "(2) Indian individuals;
21 "(3) urban Indian organizations and other In-
22 dian organizations;
23 "(4) behavioral health service providers.
24 "(d) PUBLICATION.—The memorandum of agree-
25 ment under subsection (a) shall be published in the Fed-

1 eral Register. At the same time as the publication of such
2 agreement in the Federal Register, the Secretary shall
3 provide a copy of such memorandum to each Indian tribe,
4 tribal organization, and urban Indian organization.

5 **"SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PRE-**
6 **VENTION AND TREATMENT PROGRAM.**

7 "(a) ESTABLISHMENT.—

8 "(1) IN GENERAL.—The Secretary, acting
9 through the Service, Indian tribes and tribal organi-
10 zations consistent with section 701, shall provide a
11 program of comprehensive behavioral health preven-
12 tion and treatment and aftercare, including tradi-
13 tional health care practices, which shall include—

14 "(A) prevention, through educational inter-
15 vention, in Indian communities;

16 "(B) acute detoxification or psychiatric
17 hospitalization and treatment (residential and
18 intensive outpatient);

19 "(C) community-based rehabilitation and
20 aftercare;

21 "(D) community education and involve-
22 ment, including extensive training of health
23 care, educational, and community-based person-
24 nel; and

1 "(E) specialized residential treatment pro-
2 grams for high risk populations including preg-
3 nant and post partum women and their chil-
4 dren.

5 "(2) TARGET POPULATIONS.—The target popu-
6 lation of the program under paragraph (1) shall be
7 members of Indian tribes. Efforts to train and edu-
8 cate key members of the Indian community shall
9 target employees of health, education, judicial, law
10 enforcement, legal, and social service programs.

11 "(b) CONTRACT HEALTH SERVICES.—

12 "(1) IN GENERAL.—The Secretary, acting
13 through the Service (with the consent of the Indian
14 tribe to be served), Indian tribes and tribal organiza-
15 tions, may enter into contracts with public or private
16 providers of behavioral health treatment services for
17 the purpose of carrying out the program required
18 under subsection (a).

19 "(2) PROVISION OF ASSISTANCE.—In carrying
20 out this subsection, the Secretary shall provide as-
21 sistance to Indian tribes and tribal organizations to
22 develop criteria for the certification of behavioral
23 health service providers and accreditation of service
24 facilities which meet minimum standards for such
25 services and facilities.

1 **"SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.**

2 "(a) IN GENERAL.—Under the authority of the Act
3 of November 2, 1921 (25 U.S.C. 13) (commonly known
4 as the Snyder Act), the Secretary shall establish and
5 maintain a Mental Health Technician program within the
6 Service which—

7 "(1) provides for the training of Indians as
8 mental health technicians; and

9 "(2) employs such technicians in the provision
10 of community-based mental health care that includes
11 identification, prevention, education, referral, and
12 treatment services.

13 "(b) TRAINING.—In carrying out subsection (a)(1),
14 the Secretary shall provide high standard paraprofessional
15 training in mental health care necessary to provide quality
16 care to the Indian communities to be served. Such training
17 shall be based upon a curriculum developed or approved
18 by the Secretary which combines education in the theory
19 of mental health care with supervised practical experience
20 in the provision of such care.

21 "(c) SUPERVISION AND EVALUATION.—The Sec-
22 retary shall supervise and evaluate the mental health tech-
23 nicians in the training program under this section.

24 "(d) TRADITIONAL CARE.—The Secretary shall en-
25 sure that the program established pursuant to this section
26 involves the utilization and promotion of the traditional

1 Indian health care and treatment practices of the Indian
2 tribes to be served.–

3 **"SEC. 705. LICENSING REQUIREMENT FOR MENTAL**
4 **HEALTH CARE WORKERS.**

5 "Subject to section 220, any person employed as a
6 psychologist, social worker, or marriage and family thera-
7 pist for the purpose of providing mental health care serv-
8 ices to Indians in a clinical setting under the authority
9 of this Act or through a funding agreement pursuant to
10 the Indian Self-Determination and Education Assistance
11 Act shall—

12 "(1) in the case of a person employed as a psy-
13 chologist to provide health care services, be licensed
14 as a clinical or counseling psychologist, or working
15 under the direct supervision of a clinical or counsel-
16 ing psychologist;

17 "(2) in the case of a person employed as a so-
18 cial worker, be licensed as a social worker or work-
19 ing under the direct supervision of a licensed social
20 worker; or

21 "(3) in the case of a person employed as a mar-
22 riage and family therapist, be licensed as a marriage
23 and family therapist or working under the direct su-
24 pervision of a licensed marriage and family thera-
25 pist.

1 "SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

2 "(a) FUNDING.—The Secretary, consistent with sec-
3 tion 701, shall make funding available to Indian tribes,
4 tribal organizations and urban Indian organization to de-
5 velop and implement a comprehensive behavioral health
6 program of prevention, intervention, treatment, and re-
7 lapse prevention services that specifically addresses the
8 spiritual, cultural, historical, social, and child care needs
9 of Indian women, regardless of age.

10 "(b) USE OF FUNDS.—Funding provided pursuant to
11 this section may be used to—

12 "(1) develop and provide community training,
13 education, and prevention programs for Indian
14 women relating to behavioral health issues, including
15 fetal alcohol disorders;

16 "(2) identify and provide psychological services,
17 counseling, advocacy, support, and relapse preven-
18 tion to Indian women and their families; and

19 "(3) develop prevention and intervention models
20 for Indian women which incorporate traditional
21 health care practices, cultural values, and commu-
22 nity and family involvement.

23 "(c) CRITERIA.—The Secretary, in consultation with
24 Indian tribes and tribal organizations, shall establish cri-
25 teria for the review and approval of applications and pro-
26 posals for funding under this section.

1 "(d) EARMARK OF CERTAIN FUNDS.—Twenty per-
2 cent of the amounts appropriated to carry out this section
3 shall be used to make grants to urban Indian organiza-
4 tions funded under title V.

5 **"SEC. 707. INDIAN YOUTH PROGRAM.**

6 "(a) DETOXIFICATION AND REHABILITATION.—The
7 Secretary shall, consistent with section 701, develop and
8 implement a program for acute detoxification and treat-
9 ment for Indian youth that includes behavioral health
10 services. The program shall include regional treatment
11 centers designed to include detoxification and rehabilita-
12 tion for both sexes on a referral basis and programs devel-
13 oped and implemented by Indian tribes or tribal organiza-
14 tions at the local level under the Indian Self-Determina-
15 tion and Education Assistance Act. Regional centers shall
16 be integrated with the intake and rehabilitation programs
17 based in the referring Indian community.

18 "(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT
19 CENTERS OR FACILITIES.—

20 "(1) ESTABLISHMENT.—

21 "(A) IN GENERAL.—The Secretary, acting
22 through the Service, Indian tribes, or tribal or-
23 ganizations, shall construct, renovate, or, as
24 necessary, purchase, and appropriately staff
25 and operate, at least 1 youth regional treatment

1 center or treatment network in each area under
2 the jurisdiction of an area office.
3 "(B) AREA OFFICE IN CALIFORNIA.—For
4 purposes of this subsection, the area office in
5 California shall be considered to be 2 area of-
6 fices, 1 office whose jurisdiction shall be consid-
7 ered to encompass the northern area of the
8 State of California, and 1 office whose jurisdic-
9 tion shall be considered to encompass the re-
10 mainder of the State of California for the pur-
11 pose of implementing California treatment net-
12 works.
13 "(2) FUNDING.—For the purpose of staffing
14 and operating centers or facilities under this sub-
15 section, funding shall be made available pursuant to
16 the Act of November 2, 1921 (25 U.S.C. 13) (com-
17 monly known as the Snyder Act).
18 "(3) LOCATION.—A youth treatment center
19 constructed or purchased under this subsection shall
20 be constructed or purchased at a location within the
21 area described in paragraph (1) that is agreed upon
22 (by appropriate tribal resolution) by a majority of
23 the tribes to be served by such center.
24 "(4) SPECIFIC PROVISION OF FUNDS.—

1 "(A) IN GENERAL.—Notwithstanding any
2 other provision of this title, the Secretary may,
3 from amounts authorized to be appropriated for
4 the purposes of carrying out this section, make
5 funds available to—
6 "(i) the Tanana Chiefs Conference,
7 Incorporated, for the purpose of leasing,
8 constructing, renovating, operating and
9 maintaining a residential youth treatment
10 facility in Fairbanks, Alaska;
11 "(ii) the Southeast Alaska Regional
12 Health Corporation to staff and operate a
13 residential youth treatment facility without
14 regard to the proviso set forth in section
15 4(l) of the Indian Self-Determination and
16 Education Assistance Act (25 U.S.C.
17 450b(l));
18 "(iii) the Southern Indian Health
19 Council, for the purpose of staffing, oper-
20 ating, and maintaining a residential youth
21 treatment facility in San Diego County,
22 California; and
23 "(iv) the Navajo Nation, for the staff-
24 ing, operation, and maintenance of the
25 Four Corners Regional Adolescent Treat-

1 ment Center, a residential youth treatment
2 facility in New Mexico.
3 "(B) PROVISION OF SERVICES TO ELIGI-
4 BLE YOUTH.—Until additional residential youth
5 treatment facilities are established in Alaska
6 pursuant to this section, the facilities specified
7 in subparagraph (A) shall make every effort to
8 provide services to all eligible Indian youth re-
9 siding in such State.
10 "(c) INTERMEDIATE ADOLESCENT BEHAVIORAL
11 HEALTH SERVICES.—
12 "(1) IN GENERAL.—The Secretary, acting
13 through the Service, Indian Tribes and tribal organi-
14 zations, may provide intermediate behavioral health
15 services, which may incorporate traditional health
16 care practices, to Indian children and adolescents,
17 including—
18 "(A) pre-treatment assistance;
19 "(B) inpatient, outpatient, and after-care
20 services;
21 "(C) emergency care;
22 "(D) suicide prevention and crisis interven-
23 tion; and
24 "(E) prevention and treatment of mental
25 illness, and dysfunctional and –self-destructive

1 behavior, including child abuse and family vio-
2 lence.
3 "(2) USE OF FUNDS.—Funds provided under
4 this subsection may be used—
5 "(A) to construct or renovate an existing
6 health facility to provide intermediate behav-
7 ioral health services;
8 "(B) to hire behavioral health profes-
9 sionals;
10 "(C) to staff, operate, and maintain an in-
11 termediate mental health facility, group home,
12 sober housing, transitional housing or similar
13 facilities, or youth shelter where intermediate
14 behavioral health services are being provided;
15 and
16 "(D) to make renovations and hire appro-
17 priate staff to convert existing hospital beds
18 into adolescent psychiatric units; and
19 "(E) intensive home and community based
20 services.
21 "(3) CRITERIA.—The Secretary shall, in con-
22 sultation with Indian tribes and tribal organizations,
23 establish criteria for the review and approval of ap-
24 plications or proposals for funding made available
25 pursuant to this subsection.

1 "(d) FEDERALLY OWNED STRUCTURES.—

2 "(1) IN GENERAL.—The Secretary, acting
3 through the Service, shall, in consultation with In-
4 dian tribes and tribal organizations—

5 "(A) identify and use, where appropriate,
6 federally owned structures suitable for local res-
7 idential or regional behavioral health treatment
8 for Indian youth; and

9 "(B) establish guidelines, in consultation
10 with Indian tribes and tribal organizations, for
11 determining the suitability of any such Feder-
12 ally owned structure to be used for local resi-
13 dential or regional behavioral health treatment
14 for Indian youth.

15 "(2) TERMS AND CONDITIONS FOR USE OF
16 STRUCTURE.—Any structure described in paragraph
17 (1) may be used under such terms and conditions as
18 may be agreed upon by the Secretary and the agency
19 having responsibility for the structure and any In-
20 dian tribe or tribal organization operating the pro-
21 gram.

22 "(e) REHABILITATION AND AFTERCARE SERVICES.—

23 "(1) IN GENERAL.—The Secretary, an Indian
24 tribe or tribal organization, in cooperation with the
25 Secretary of the Interior, shall develop and imple-

1 ment within each service unit, community-based re-
2 habilitation and follow-up services for Indian youth
3 who have significant behavioral health problems, and
4 require long-term treatment, community reintegra-
5 tion, and monitoring to support the Indian youth
6 after their return to their home community.

7 "(2) ADMINISTRATION.—Services under para-
8 graph (1) shall be administered within each service
9 unit or tribal program by trained staff within the
10 community who can assist the Indian youth in con-
11 tinuing development of self-image, positive problem-
12 solving skills, and nonalcohol or substance abusing
13 behaviors. Such staff may include alcohol and sub-
14 stance abuse counselors, mental health professionals,
15 and other health professionals and paraprofessionals,
16 including community health representatives.

17 "(f) INCLUSION OF FAMILY IN YOUTH TREATMENT
18 PROGRAM.—In providing the treatment and other services
19 to Indian youth authorized by this section, the Secretary,
20 an Indian tribe or tribal organization shall provide for the
21 inclusion of family members of such youth in the treat-
22 ment programs or other services as may be appropriate.
23 Not less than 10 percent of the funds appropriated for
24 the purposes of carrying out subsection (e) shall be used

1 for outpatient care of adult family members related to the
2 treatment of an Indian youth under that subsection.
3 "(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
4 acting through the Service, Indian tribes, tribal organiza-
5 tions and urban Indian organizations, shall provide, con-
6 sistent with section 701, programs and services to prevent
7 and treat the abuse of multiple forms of substances, in-
8 cluding alcohol, drugs, inhalants, and tobacco, among In-
9 dian youth residing in Indian communities, on Indian res-
10 ervations, and in urban areas and provide appropriate
11 mental health services to address the incidence of mental
12 illness among such youth.

13 **"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL**
14 **HEALTH FACILITIES DESIGN, CONSTRUCTION**
15 **AND STAFFING ASSESSMENT.—**

16 "(a) IN GENERAL.—Not later than 1 year after the
17 date of enactment of this section, the Secretary, acting
18 through the Service, Indian tribes and tribal organiza-
19 tions, shall provide, in each area of the Service, not less
20 than 1 inpatient mental health care facility, or the equiva-
21 lent, for Indians with behavioral health problems.
22 "(b) TREATMENT OF CALIFORNIA.—For purposes of
23 this section, California shall be considered to be 2 areas
24 of the Service, 1 area whose location shall be considered
25 to encompass the northern area of the State of California

1 and 1 area whose jurisdiction shall be considered to en-
2 compass the remainder of the State of California.
3 "(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—
4 The Secretary shall consider the possible conversion of ex-
5 isting, under-utilized Service hospital beds into psychiatric
6 units to meet needs under this section.–
7 **"SEC. 709. TRAINING AND COMMUNITY EDUCATION.**
8 "(a) COMMUNITY EDUCATION.—
9 "(1) IN GENERAL.—The Secretary, in coopera-
10 tion with the Secretary of the Interior, shall develop
11 and implement, or provide funding to enable Indian
12 tribes and tribal organization to develop and imple-
13 ment, within each service unit or tribal program a
14 program of community education and involvement
15 which shall be designed to provide concise and timely
16 information to the community leadership of each
17 tribal community.
18 "(2) EDUCATION.—A program under paragraph
19 (1) shall include education concerning behavioral
20 health for political leaders, tribal judges, law en-
21 forcement personnel, members of tribal health and
22 education boards, and other critical members of each
23 tribal community.
24 "(3) TRAINING.—Community-based training
25 (oriented toward local capacity development) under a

1 program under paragraph (1) shall include tribal
2 community provider training (designed for adult
3 learners from the communities receiving services for
4 prevention, intervention, treatment and aftercare).
5 "(b) TRAINING.—The Secretary shall, either directly
6 or through Indian tribes or tribal organization, provide in-
7 struction in the area of behavioral health issues, including
8 instruction in crisis intervention and family relations in
9 the context of alcohol and substance abuse, child sexual
10 abuse, youth alcohol and substance abuse, and the causes
11 and effects of fetal alcohol disorders, to appropriate em-
12 ployees of the Bureau of Indian Affairs and the Service,
13 and to personnel in schools or programs operated under
14 any contract with the Bureau of Indian Affairs or the
15 Service, including supervisors of emergency shelters and
16 halfway houses described in section 4213 of the Indian
17 Alcohol and Substance Abuse Prevention and Treatment
18 Act of 1986 (25 U.S.C. 2433).
19 "(c) COMMUNITY-BASED TRAINING MODELS.—In
20 carrying out the education and training programs required
21 by this section, the Secretary, acting through the Service
22 and in consultation with Indian tribes, tribal organiza-
23 tions, Indian behavioral health experts, and Indian alcohol
24 and substance abuse prevention experts, shall develop and

1 provide community-based training models. Such models
2 shall address—
3 "(1) the elevated risk of alcohol and behavioral
4 health problems faced by children of alcoholics;
5 "(2) the cultural, spiritual, and
6 multigenerational aspects of behavioral health prob-
7 lem prevention and recovery; and
8 "(3) community-based and multidisciplinary
9 strategies for preventing and treating behavioral
10 health problems.
11 **"SEC. 710. BEHAVIORAL HEALTH PROGRAM.**
12 "(a) PROGRAMS FOR INNOVATIVE SERVICES.—The
13 Secretary, acting through the Service, Indian Tribes or
14 tribal organizations, consistent with Section 701, may de-
15 velop, implement, and carry out programs to deliver inno-
16 vative community-based behavioral health services to Indi-
17 ans.
18 "(b) CRITERIA.—The Secretary may award funding
19 for a project under subsection (a) to an Indian tribe or
20 tribal organization and may consider the following criteria:
21 "(1) Whether the project will address signifi-
22 cant unmet behavioral health needs among Indians.
23 "(2) Whether the project will serve a significant
24 number of Indians.

1 "(3) Whether the project has the potential to
2 deliver services in an efficient and effective manner.
3 "(4) Whether the tribe or tribal organization
4 has the administrative and financial capability to ad-
5 minister the project.
6 "(5) Whether the project will deliver services in
7 a manner consistent with traditional health care.
8 "(6) Whether the project is coordinated with,
9 and avoids duplication of, existing services.
10 "(c) FUNDING AGREEMENTS.—For purposes of this
11 subsection, the Secretary shall, in evaluating applications
12 or proposals for funding for projects to be operated under
13 any funding agreement entered into with the Service
14 under the Indian Self-Determination Act and Education
15 Assistance Act, use the same criteria that the Secretary
16 uses in evaluating any other application or proposal for
17 such funding.
18 **"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.**
19 "(a) ESTABLISHMENT OF PROGRAM.—
20 "(1) IN GENERAL.—The Secretary, consistent
21 with Section 701, acting through Indian tribes, trib-
22 al organizations, and urban Indian organizations,
23 shall establish and operate fetal alcohol disorders
24 programs as provided for in this section for the pur-

1 poses of meeting the health status objective specified
2 in section 3(b).
3 "(2) USE OF FUNDS.—Funding provided pursu-
4 ant to this section shall be used to—
5 "(A) develop and provide community and
6 in-school training, education, and prevention
7 programs relating to fetal alcohol disorders;
8 "(B) identify and provide behavioral health
9 treatment to high-risk women;
10 "(C) identify and provide appropriate edu-
11 cational and vocational support, counseling, ad-
12 vocacy, and information to fetal alcohol disorder
13 affected persons and their families or care-
14 takers;
15 "(D) develop and implement counseling
16 and support programs in schools for fetal alco-
17 hol disorder affected children;
18 "(E) develop prevention and intervention
19 models which incorporate traditional practition-
20 ers, cultural and spiritual values and commu-
21 nity involvement;
22 "(F) develop, print, and disseminate edu-
23 cation and prevention materials on fetal alcohol
24 disorders;

1 "(G) develop and implement, through the
2 tribal consultation process, culturally sensitive
3 assessment and diagnostic tools including
4 dysmorphology clinics and multidisciplinary
5 fetal alcohol disorder clinics for use in tribal
6 and urban Indian communities;
7 "(H) develop early childhood intervention
8 projects from birth on to mitigate the effects of
9 fetal alcohol disorders; and
10 "(I) develop and fund community-based
11 adult fetal alcohol disorder housing and support
12 services.
13 "(3) CRITERIA.—The Secretary shall establish
14 criteria for the review and approval of applications
15 for funding under this section.
16 "(b) PROVISION OF SERVICES.—The Secretary, act-
17 ing through the Service, Indian tribes, tribal organizations
18 and urban Indian organizations, shall—
19 "(1) develop and provide services for the pre-
20 vention, intervention, treatment, and aftercare for
21 those affected by fetal alcohol disorders in Indian
22 communities; and
23 "(2) provide supportive services, directly or
24 through an Indian tribe, tribal organization or urban
25 Indian organization, including services to meet the

1 special educational, vocational, school-to-work transi-
2 tion, and independent living needs of adolescent and
3 adult Indians with fetal alcohol disorders.
4 "(c) TASK FORCE.—
5 "(1) IN GENERAL.—The Secretary shall estab-
6 lish a task force to be known as the Fetal Alcohol
7 Disorders Task Force to advise the Secretary in car-
8 rying out subsection (b).
9 "(2) COMPOSITION.—The task force under
10 paragraph (1) shall be composed of representatives
11 from the National Institute on Drug Abuse, the Na-
12 tional Institute on Alcohol and Alcoholism, the Of-
13 fice of Substance Abuse Prevention, the National In-
14 stitute of Mental Health, the Service, the Office of
15 Minority Health of the Department of Health and
16 Human Services, the Administration for Native
17 Americans, the National Institute of Child Health
18 & Human Development, the Centers for Disease
19 Control and Prevention, the Bureau of Indian Af-
20 fairs, Indian tribes, tribal organizations, urban In-
21 dian communities, and Indian fetal alcohol disorders
22 experts.
23 "(d) APPLIED RESEARCH.—The Secretary, acting
24 through the Substance Abuse and Mental Health Services
25 Administration, shall make funding available to Indian

1 Tribes, tribal organizations and urban Indian organiza-
2 tions for applied research projects which propose to elevate
3 the understanding of methods to prevent, intervene, treat,
4 or provide rehabilitation and behavioral health aftercare
5 for Indians and urban Indians affected by fetal alcohol
6 disorders.

7 "(e) URBAN INDIAN ORGANIZATIONS.—The Sec-
8 retary shall ensure that 10 percent of the amounts appro-
9 priated to carry out this section shall be used to make
10 grants to urban Indian organizations funded under title
11 V.

12 **"SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREAT-**
13 **MENT PROGRAMS.**

14 "(a) ESTABLISHMENT.—The Secretary and the Sec-
15 retary of the Interior, acting through the Service, Indian
16 tribes and tribal organizations, shall establish, consistent
17 with section 701, in each service area, programs involving
18 treatment for—

19 "(1) victims of child sexual abuse; and

20 "(2) perpetrators of child sexual abuse.

21 "(b) USE OF FUNDS.—Funds provided under this
22 section shall be used to—

23 "(1) develop and provide community education
24 and prevention programs related to child sexual
25 abuse;

1 "(2) identify and provide behavioral health
2 treatment to children who are victims of sexual
3 abuse and to their families who are affected by sex-
4 ual abuse;
5 "(3) develop prevention and intervention models
6 which incorporate traditional health care practition-
7 ers, cultural and spiritual values, and community in-
8 volvement;
9 "(4) develop and implement, though the tribal
10 consultation process, culturally sensitive assessment
11 and diagnostic tools for use in tribal and urban In-
12 dian communities.
13 "(5) identify and provide behavioral health
14 treatment to perpetrators of child sexual abuse with
15 efforts being made to begin offender and behavioral
16 health treatment while the perpetrator is incarcer-
17 ated or at the earliest possible date if the perpetra-
18 tor is not incarcerated, and to provide treatment
19 after release to the community until it is determined
20 that the perpetrator is not a threat to children.
21 **"SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.**
22 "(a) IN GENERAL.—The Secretary, acting through
23 the Service and in consultation with appropriate Federal
24 agencies, shall provide funding to Indian Tribes, tribal or-
25 ganizations and urban Indian organizations or, enter into

1 contracts with, or make grants to appropriate institutions,
2 for the conduct of research on the incidence and preva-
3 lence of behavioral health problems among Indians served
4 by the Service, Indian Tribes or tribal organizations and
5 among Indians in urban areas. Research priorities under
6 this section shall include—

7 "(1) the inter-relationship and inter-dependance
8 of behavioral health problems with alcoholism and
9 other substance abuse, suicide, homicides, other in-
10 juries, and the incidence of family violence; and

11 "(2) the development of models of prevention
12 techniques.

13 "(b) SPECIAL EMPHASIS.—The effect of the inter-re-
14 lationships and interdependencies referred to in subsection
15 (a)(1) on children, and the development of prevention
16 techniques under subsection (a)(2) applicable to children,
17 shall be emphasized.

18 **"SEC. 714. DEFINITIONS.**

19 "In this title:

20 "(1) ASSESSMENT.—The term 'assessment'
21 means the systematic collection, analysis and dis-
22 semination of information on health status, health
23 needs and health problems.

24 "(2) ALCOHOL RELATED NEURODEVELOP-MEN-
25 TAL DISORDERS.—The term 'alcohol related

1 neurodevelop-mental disorders' or 'ARND' with re-
2 spect to an individual means the individual has a
3 history of maternal alcohol consumption during
4 pregnancy, central nervous system involvement such
5 as developmental delay, intellectual deficit, or
6 neurologic abnormalities, that behaviorally, there
7 may be problems with irritability, and failure to
8 thrive as infants, and that as children become older
9 there will likely be hyperactivity, attention deficit,
10 language dysfunction and perceptual and judgment
11 problems.

12 "(3) BEHAVIORAL HEALTH.—The term 'behav-
13 ioral health' means the blending of substances (alco-
14 hol, drugs, inhalants and tobacco) abuse and mental
15 health prevention and treatment, for the purpose of
16 providing comprehensive services. Such term in-
17 cludes the joint development of substance abuse and
18 mental health treatment planning and coordinated
19 case management using a multidisciplinary ap-
20 proach.

21 "(4) BEHAVIORAL HEALTH AFTERCARE.—

22 "(A) IN GENERAL.—The term 'behavioral
23 health aftercare' includes those activities and
24 resources used to support recovery following in-
25 patient, residential, intensive substance abuse

1 or mental health outpatient or outpatient treat-
2 ment, to help prevent or treat relapse, including
3 the development of an aftercare plan.
4 "(B) AFTERCARE PLAN.—Prior to the
5 time at which an individual is discharged from
6 a level of care, such as outpatient treatment, an
7 aftercare plan shall have been developed for the
8 individual. Such plan may use such resources as
9 community base therapeutic group care, transi-
10 tional living, a 12-step sponsor, a local 12-step
11 or other related support group, or other com-
12 munity based providers (such as mental health
13 professionals, traditional health care practition-
14 ers, community health aides, community health
15 representatives, mental health technicians, or
16 ministers).
17 "(5) DUAL DIAGNOSIS.—The term 'dual diag-
18 nosis' means coexisting substance abuse and mental
19 illness conditions or diagnosis. In individual with a
20 dual diagnosis may be referred to as a mentally ill
21 chemical abuser.–
22 "(6) FETAL ALCOHOL DISORDERS.—The term
23 'fetal alcohol disorders' means fetal alcohol syn-
24 drome, partial fetal alcohol syndrome, or alcohol re-
25 lated neural developmental disorder.

1 "(7) FETAL ALCOHOL SYNDROME.—The term
2 'fetal alcohol syndrome' or 'FAS' with respect to an
3 individual means a syndrome in which the individual
4 has a history of maternal alcohol consumption dur-
5 ing pregnancy, and with respect to which the follow-
6 ing criteria should be met:
7 "(A) Central nervous system involvement
8 such as developmental delay, intellectual deficit,
9 microencephaly, or neurologic abnormalities.
10 "(B) Craniofacial abnormalities with at
11 least 2 of the following: microphthalmia, short
12 palpebral fissures, poorly developed philtrum,
13 thin upper lip, flat nasal bridge, and short
14 upturned nose.
15 "(C) Prenatal or postnatal growth delay.
16 "(8) PARTIAL FAS.—The term 'partial FAS'
17 with respect to an individual means a history of ma-
18 ternal alcohol consumption during pregnancy having
19 most of the criteria of FAS, though not meeting a
20 minimum of at least 2 of the following: micro-oph-
21 thalmia, short palpebral fissures, poorly developed
22 philtrum, thin upper lip, flat nasal bridge, short
23 upturned nose.
24 "(9) REHABILITATION.—The term 'rehabilita-
25 tion' means to restore the ability or capacity to en-

1 gage in usual and customary life activities through
2 education and therapy.–
3 "(10) SUBSTANCE ABUSE.—The term 'sub-
4 stance abuse' includes inhalant abuse. —

5 **"SEC. 715. AUTHORIZATION OF APPROPRIATIONS.**

6 "There is authorized to be appropriated such sums
7 as may be necessary for each fiscal year through fiscal
8 year 2012 to carry out this title.

9 "TITLE VIII—MISCELLANEOUS

10 **"SEC. 801. REPORTS.**

11 "The President shall, at the time the budget is sub-
12 mitted under section 1105 of title 31, United States Code,
13 for each fiscal year transmit to the Congress a report
14 containing—
15 "(1) a report on the progress made in meeting
16 the objectives of this Act, including a review of pro-
17 grams established or assisted pursuant to this Act
18 and an assessment and recommendations of addi-
19 tional programs or additional assistance necessary
20 to, at a minimum, provide health services to Indians,
21 and ensure a health status for Indians, which are at
22 a parity with the health services available to and the
23 health status of, the general population, including
24 specific comparisons of appropriations provided and
25 those required for such parity;

1 "(2) a report on whether, and to what extent,
2 new national health care programs, benefits, initia-
3 tives, or financing systems have had an impact on
4 the purposes of this Act and any steps that the Sec-
5 retary may have taken to consult with Indian tribes
6 to address such impact, including a report on pro-
7 posed changes in the allocation of funding pursuant
8 to section 808;
9 "(3) a report on the use of health services by
10 Indians—
11 "(A) on a national and area or other rel-
12 evant geographical basis;
13 "(B) by gender and age;
14 "(C) by source of payment and type of
15 service;
16 "(D) comparing such rates of use with
17 rates of use among comparable non-Indian pop-
18 ulations; and
19 "(E) on the services provided under fund-
20 ing agreements pursuant to the Indian Self-De-
21 termination and Education Assistance Act;
22 "(4) a report of contractors concerning health
23 care educational loan repayments under section 110;

1 "(5) a general audit report on the health care
2 educational loan repayment program as required
3 under section 110(n);
4 "(6) a separate statement that specifies the
5 amount of funds requested to carry out the provi-
6 sions of section 201;
7 "(7) a report on infectious diseases as required
8 under section 212;
9 "(8) a report on environmental and nuclear
10 health hazards as required under section 214;
11 "(9) a report on the status of all health care fa-
12 cilities needs as required under sections 301(c)(2)
13 and 301(d);
14 "(10) a report on safe water and sanitary waste
15 disposal facilities as required under section
16 302(h)(1);
17 "(11) a report on the expenditure of non-service
18 funds for renovation as required under sections
19 305(a)(2) and 305(a)(3);
20 "(12) a report identifying the backlog of main-
21 tenance and repair required at Service and tribal fa-
22 cilities as required under section 314(a);
23 "(13) a report providing an accounting of reim-
24 bursement funds made available to the Secretary

1 under titles XVIII and XIX of the Social Security
2 Act as required under section 403(a);
3 "(14) a report on services sharing of the Serv-
4 ice, the Department of Veteran's Affairs, and other
5 Federal agency health programs as required under
6 section 412(c)(2);
7 "(15) a report on the evaluation and renewal of
8 urban Indian programs as required under section
9 505;
10 "(16) a report on the findings and conclusions
11 derived from the demonstration project as required
12 under section 512(a)(2);
13 "(17) a report on the evaluation of programs as
14 required under section 513; and
15 "(18) a report on alcohol and substance abuse
16 as required under section 701(f).
17 **"SEC. 802. REGULATIONS.**
18 "(a) INITIATION OF RULEMAKING PROCEDURES.—
19 "(1) IN GENERAL.—Not later than 90 days
20 after the date of enactment of this Act, the Sec-
21 retary shall initiate procedures under subchapter III
22 of chapter 5 of title 5, United States Code, to nego-
23 tiate and promulgate such regulations or amend-
24 ments thereto that are necessary to carry out this
25 Act.

1 "(2) PUBLICATION.—Proposed regulations to
2 implement this Act shall be published in the Federal
3 Register by the Secretary not later than 270 days
4 after the date of enactment of this Act and shall
5 have not less than a 120 day comment period.
6 "(3) EXPIRATION OF AUTHORITY.—The author-
7 ity to promulgate regulations under this Act shall
8 expire 18 months from the date of enactment of this
9 Act.
10 "(b) RULEMAKING COMMITTEE.—A negotiated rule-
11 making committee established pursuant to section 565 of
12 Title 5, United States Code, to carry out this section shall
13 have as its members only representatives of the Federal
14 Government and representatives of Indian tribes, and trib-
15 al organizations, a majority of whom shall be nominated
16 by and be representatives of Indian tribes, tribal organiza-
17 tions, and urban Indian organizations from each service
18 area.
19 "(c) ADAPTION OF PROCEDURES.—The Secretary
20 shall adapt the negotiated rulemaking procedures to the
21 unique context of self-governance and the government-to-
22 government relationship between the United States and
23 Indian Tribes.

1 "(d) FAILURE TO PROMULGATE REGULATIONS.—
2 The lack of promulgated regulations shall not limit the
3 effect of this Act.

4 "(e) SUPREMACY OF PROVISIONS.—The provisions of
5 this Act shall supersede any conflicting provisions of law
6 (including any conflicting regulations) in effect on the day
7 before the date of enactment of the Indian Self-Deter-
8 mination Contract Reform Act of 1994, and the Secretary
9 is authorized to repeal any regulation that is inconsistent
10 with the provisions of this Act.

11 **"SEC. 803. PLAN OF IMPLEMENTATION.**

12 "Not later than 240 days after the date of enactment
13 of this Act, the Secretary, in consultation with Indian
14 tribes, tribal organizations, and urban Indian organiza-
15 tions, shall prepare and submit to Congress a plan that
16 shall explain the manner and schedule (including a sched-
17 ule of appropriate requests), by title and section, by which
18 the Secretary will implement the provisions of this Act.

19 **"SEC. 804. AVAILABILITY OF FUNDS.**

20 "Amounts appropriated under this Act shall remain
21 available until expended.

22 **"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED**
23 **TO THE INDIAN HEALTH SERVICE.**

24 "Any limitation on the use of funds contained in an
25 Act providing appropriations for the Department for a pe-

1 riod with respect to the performance of abortions shall
2 apply for that period with respect to the performance of
3 abortions using funds contained in an Act providing ap-
4 propriations for the Service.

5 **"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.**

6 "(a) ELIGIBILITY.—

7 "(1) IN GENERAL.—Until such time as any
8 subsequent law may otherwise provide, the following
9 California Indians shall be eligible for health services
10 provided by the Service:

11 "(1) Any member of a Federally recog-
12 nized Indian tribe.

13 "(2) Any descendant of an Indian who was
14 residing in California on June 1, 1852, but only
15 if such descendant—

16 "(A) is a member of the Indian com-
17 munity served by a local program of the
18 Service; and

19 "(B) is regarded as an Indian by the
20 community in which such descendant lives.

21 "(3) Any Indian who holds trust interests
22 in public domain, national forest, or Indian res-
23 ervation allotments in California.

24 "(4) Any Indian in California who is listed
25 on the plans for distribution of the assets of

1 California rancherias and reservations under
2 the Act of August 18, 1958 (72 Stat. 619), and
3 any descendant of such an Indian.
4 "(b) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion may be construed as expanding the eligibility of Cali-
6 fornia Indians for health services provided by the Service
7 beyond the scope of eligibility for such health services that
8 applied on May 1, 1986.
9 **"SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.**
10 "(a) INELIGIBLE PERSONS.—
11 "(1) IN GENERAL.—Any individual who—
12 "(A) has not attained 19 years of age;
13 "(B) is the natural or adopted child, step-
14 child, foster-child, legal ward, or orphan of an
15 eligible Indian; and
16 "(C) is not otherwise eligible for the health
17 services provided by the Service,
18 shall be eligible for all health services provided by
19 the Service on the same basis and subject to the
20 same rules that apply to eligible Indians until such
21 individual attains 19 years of age. The existing and
22 potential health needs of all such individuals shall be
23 taken into consideration by the Service in determin-
24 ing the need for, or the allocation of, the health re-
25 sources of the Service. If such an individual has

1 been determined to be legally incompetent prior to
2 attaining 19 years of age, such individual shall re-
3 main eligible for such services until one year after
4 the date such disability has been removed.

5 "(2) SPOUSES.—Any spouse of an eligible In-
6 dian who is not an Indian, or who is of Indian de-
7 scent but not otherwise eligible for the health serv-
8 ices provided by the Service, shall be eligible for
9 such health services if all of such spouses or spouses
10 who are married to members of the Indian tribe
11 being served are made eligible, as a class, by an ap-
12 propriate resolution of the governing body of the In-
13 dian tribe or tribal organization providing such serv-
14 ices. The health needs of persons made eligible
15 under this paragraph shall not be taken into consid-
16 eration by the Service in determining the need for,
17 or allocation of, its health resources.

18 "(b) PROGRAMS AND SERVICES.—

19 "(1) PROGRAMS.—

20 "(A) IN GENERAL.—The Secretary may
21 provide health services under this subsection
22 through health programs operated directly by
23 the Service to individuals who reside within the
24 service area of a service unit and who are not
25 eligible for such health services under any other

1 subsection of this section or under any other
2 provision of law if—
3 "(i) the Indian tribe (or, in the case
4 of a multi-tribal service area, all the Indian
5 tribes) served by such service unit requests
6 such provision of health services to such
7 individuals; and
8 "(ii) the Secretary and the Indian
9 tribe or tribes have jointly determined
10 that—
11 "(I) the provision of such health
12 services will not result in a denial or
13 diminution of health services to eligi-
14 ble Indians; and
15 "(II) there is no reasonable alter-
16 native health program or services,
17 within or without the service area of
18 such service unit, available to meet
19 the health needs of such individuals.
20 "(B) FUNDING AGREEMENTS.—In the case
21 of health programs operated under a funding
22 agreement entered into under the Indian Self-
23 Determination and Educational Assistance Act,
24 the governing body of the Indian tribe or tribal
25 organization providing health services under

1 such funding agreement is authorized to deter-
2 mine whether health services should be provided
3 under such funding agreement to individuals
4 who are not eligible for such health services
5 under any other subsection of this section or
6 under any other provision of law. In making
7 such determinations, the governing body of the
8 Indian tribe or tribal organization shall take
9 into account the considerations described in
10 subparagraph (A)(ii).
11 "(2) LIABILITY FOR PAYMENT.—
12 "(A) IN GENERAL.—Persons receiving
13 health services provided by the Service by rea-
14 son of this subsection shall be liable for pay-
15 ment of such health services under a schedule
16 of charges prescribed by the Secretary which, in
17 the judgment of the Secretary, results in reim-
18 bursement in an amount not less than the ac-
19 tual cost of providing the health services. Not-
20 withstanding section 1880(c) of the Social Se-
21 curity Act, section 402(a) of this Act, or any
22 other provision of law, amounts collected under
23 this subsection, including medicare or medicaid
24 reimbursements under titles XVIII and XIX of
25 the Social Security Act, shall be credited to the

1 account of the program providing the service
2 and shall be used solely for the provision of
3 health services within that program. Amounts
4 collected under this subsection shall be available
5 for expenditure within such program for not to
6 exceed 1 fiscal year after the fiscal year in
7 which collected.

8 "(B) SERVICES FOR INDIGENT PERSONS.—
9 Health services may be provided by the Sec-
10 retary through the Service under this sub-
11 section to an indigent person who would not be
12 eligible for such health services but for the pro-
13 visions of paragraph (1) only if an agreement
14 has been entered into with a State or local gov-
15 ernment under which the State or local govern-
16 ment agrees to reimburse the Service for the
17 expenses incurred by the Service in providing
18 such health services to such indigent person.

19 "(3) SERVICE AREAS.—

20 "(A) SERVICE TO ONLY ONE TRIBE.—In
21 the case of a service area which serves only one
22 Indian tribe, the authority of the Secretary to
23 provide health services under paragraph (1)(A)
24 shall terminate at the end of the fiscal year suc-
25 ceeding the fiscal year in which the governing

1 body of the Indian tribe revokes its concurrence
2 to the provision of such health services.
3 "(B) MULTI-TRIBAL AREAS.—In the case
4 of a multi-tribal service area, the authority of
5 the Secretary to provide health services under
6 paragraph (1)(A) shall terminate at the end of
7 the fiscal year succeeding the fiscal year in
8 which at least 51 percent of the number of In-
9 dian tribes in the service area revoke their con-
10 currence to the provision of such health serv-
11 ices.
12 "(c) PURPOSE FOR PROVIDING SERVICES.—The
13 Service may provide health services under this subsection
14 to individuals who are not eligible for health services pro-
15 vided by the Service under any other subsection of this
16 section or under any other provision of law in order to—
17 "(1) achieve stability in a medical emergency;
18 "(2) prevent the spread of a communicable dis-
19 ease or otherwise deal with a public health hazard;
20 "(3) provide care to non-Indian women preg-
21 nant with an eligible Indian's child for the duration
22 of the pregnancy through post partum; or
23 "(4) provide care to immediate family members
24 of an eligible person if such care is directly related
25 to the treatment of the eligible person.

1 "(d) HOSPITAL PRIVILEGES.—Hospital privileges in
2 health facilities operated and maintained by the Service
3 or operated under a contract entered into under the Indian
4 Self-Determination Education Assistance Act may be ex-
5 tended to non-Service health care practitioners who pro-
6 vide services to persons described in subsection (a) or (b).
7 Such non-Service health care practitioners may be re-
8 garded as employees of the Federal Government for pur-
9 poses of section 1346(b) and chapter 171 of title 28,
10 United States Code (relating to Federal tort claims) only
11 with respect to acts or omissions which occur in the course
12 of providing services to eligible persons as a part of the
13 conditions under which such hospital privileges are ex-
14 tended.

15 "(e) DEFINITION.—In this section, the term 'eligible
16 Indian' means any Indian who is eligible for health serv-
17 ices provided by the Service without regard to the provi-
18 sions of this section.

19 **"SEC. 808. REALLOCATION OF BASE RESOURCES.**

20 "(a) REQUIREMENT OF REPORT.—Notwithstanding
21 any other provision of law, any allocation of Service funds
22 for a fiscal year that reduces by 5 percent or more from
23 the previous fiscal year the funding for any recurring pro-
24 gram, project, or activity of a service unit may be imple-
25 mented only after the Secretary has submitted to the

1 President, for inclusion in the report required to be trans-
2 mitted to the Congress under section 801, a report on the
3 proposed change in allocation of funding, including the
4 reasons for the change and its likely effects.

5 "(b) NONAPPLICATION OF SECTION.—Subsection (a)
6 shall not apply if the total amount appropriated to the
7 Service for a fiscal year is less than the amount appro-
8 priated to the Service for previous fiscal year.

9 **"SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.**

10 "The Secretary shall provide for the dissemination to
11 Indian tribes of the findings and results of demonstration
12 projects conducted under this Act.

13 **"SEC. 810. PROVISION OF SERVICES IN MONTANA.**

14 "(a) IN GENERAL.—The Secretary, acting through
15 the Service, shall provide services and benefits for Indians
16 in Montana in a manner consistent with the decision of
17 the United States Court of Appeals for the Ninth Circuit
18 in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr.
19 1987).

20 "(b) RULE OF CONSTRUCTION.—The provisions of
21 subsection (a) shall not be construed to be an expression
22 of the sense of the Congress on the application of the deci-
23 sion described in subsection (a) with respect to the provi-
24 sion of services or benefits for Indians living in any State
25 other than Montana.

1 **"SEC. 811. MORATORIUM.**

2 "During the period of the moratorium imposed by
3 Public Law 100–446 on implementation of the final rule
4 published in the Federal Register on September 16, 1987,
5 by the Health Resources and Services Administration, re-
6 lating to eligibility for the health care services of the Serv-
7 ice, the Service shall provide services pursuant to the cri-
8 teria for eligibility for such services that were in effect
9 on September 15, 1987, subject to the provisions of sec-
10 tions 806 and 807 until such time as new criteria govern-
11 ing eligibility for services are developed in accordance with
12 section 802.

13 **"SEC. 812. TRIBAL EMPLOYMENT.**

14 "For purposes of section 2(2) of the Act of July 5,
15 1935 (49 Stat. 450, Chapter 372), an Indian tribe or trib-
16 al organization carrying out a funding agreement under
17 the Self-Determination and Education Assistance Act
18 shall not be considered an employer.

19 **"SEC. 813. PRIME VENDOR.**

20 "For purposes of section 4 of Public Law 102–585
21 (38 U.S.C. 812) Indian tribes and tribal organizations
22 carrying out a grant, cooperative agreement, or funding
23 agreement under the Indian Self-Determination and Edu-
24 cation Assistance Act (25 U.S.C. 450 et seq.) shall be
25 deemed to be an executive agency and part of the Service
26 in the and, as such, may act as an ordering agent of the

1 Service and the employees of the tribe or tribal organiza-
2 tion may order supplies on behalf thereof on the same
3 basis as employees of the Service.

4 **"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN**
5 **HEALTH CARE ENTITLEMENT.**

6 "(a) ESTABLISHMENT.—There is hereby established
7 the National Bi-Partisan Indian Health Care Entitlement
8 Commission (referred to in this Act as the 'Commission').

9 "(b) MEMBERSHIP.—The Commission shall be com-
10 posed of 25 members, to be appointed as follows:

11 "(1) Ten members of Congress, of which—

12 "(A) three members shall be from the
13 House of Representatives and shall be ap-
14 pointed by the majority leader;

15 "(B) three members shall be from the
16 House of Representatives and shall be ap-
17 pointed by the minority leader;

18 "(C) two members shall be from the Sen-
19 ate and shall be appointed by the majority lead-
20 er; and

21 "(D) two members shall be from the Sen-
22 ate and shall be appointed by the minority lead-
23 er;

24 who shall each be members of the committees of
25 Congress that consider legislation affecting the pro-

1 vision of health care to Indians and who shall elect
2 the chairperson and vice-chairperson of the Commis-
3 sion.
4 "(2) Twelve individuals to be appointed by the
5 members of the Commission appointed under para-
6 graph (1), of which at least 1 shall be from each
7 service area as currently designated by the Director
8 of the Service, to be chosen from among 3 nominees
9 from each such area as selected by the Indian tribes
10 within the area, with due regard being given to the
11 experience and expertise of the nominees in the pro-
12 vision of health care to Indians and with due regard
13 being given to a reasonable representation on the
14 Commission of members who are familiar with var-
15 ious health care delivery modes and who represent
16 tribes of various size populations.
17 "(3) Three individuals shall be appointed by the
18 Director of the Service from among individual who
19 are knowledgeable about the provision of health care
20 to Indians, at least 1 of whom shall be appointed
21 from among 3 nominees from each program that is
22 funded in whole or in part by the Service primarily
23 or exclusively for the benefit of urban Indians.
24 All those persons appointed under paragraphs (2) and (3)
25 shall be members of Federally recognized Indian Tribes.

1 "(c) TERMS.—

2 "(1) IN GENERAL.—Members of the Commis-
3 sion shall serve for the life of the Commission.

4 "(2) APPOINTMENT OF MEMBERS.—Members of
5 the Commission shall be appointed under subsection
6 (b)(1) not later than 90 days after the date of enact-
7 ment of this Act, and the remaining members of the
8 Commission shall be appointed not later than 60
9 days after the date on which the members are ap-
10 pointed under such subsection.

11 "(3) VACANCY.—A vacancy in the membership
12 of the Commission shall be filled in the manner in
13 which the original appointment was made.

14 "(d) DUTIES OF THE COMMISSION.—The Commis-
15 sion shall carry out the following duties and functions:

16 "(1) Review and analyze the recommendations
17 of the report of the study committee established
18 under paragraph (3) to the Commission.

19 "(2) Make recommendations to Congress for
20 providing health services for Indian persons as an
21 entitlement, giving due regard to the effects of such
22 a programs on existing health care delivery systems
23 for Indian persons and the effect of such programs
24 on the sovereign status of Indian Tribes;

1 "(3) Establish a study committee to be com-
2 posed of those members of the Commission ap-
3 pointed by the Director of the Service and at least
4 4 additional members of Congress from among the
5 members of the Commission which shall—
6 "(A) to the extent necessary to carry out
7 its duties, collect and compile data necessary to
8 understand the extent of Indian needs with re-
9 gard to the provision of health services, regard-
10 less of the location of Indians, including holding
11 hearings and soliciting the views of Indians, In-
12 dian tribes, tribal organizations and urban In-
13 dian organizations, and which may include au-
14 thorizing and funding feasibility studies of var-
15 ious models for providing and funding health
16 services for all Indian beneficiaries including
17 those who live outside of a reservation, tempo-
18 rarily or permanently;
19 "(B) make recommendations to the Com-
20 mission for legislation that will provide for the
21 delivery of health services for Indians as an en-
22 titlement, which shall, at a minimum, address
23 issues of eligibility, benefits to be provided, in-
24 cluding recommendations regarding from whom
25 such health services are to be provide,d and the

1 cost, including mechanisms for funding of the
2 health services to be provided;
3 "(C) determine the effect of the enactment
4 of such recommendations on the existing system
5 of the delivery of health services for Indians;
6 "(D) determine the effect of a health serv-
7 ices entitlement program for Indian persons on
8 the sovereign status of Indian tribes;
9 "(E) not later than 12 months after the
10 appointment of all members of the Commission,
11 make a written report of its findings and rec-
12 ommendations to the Commission, which report
13 shall include a statement of the minority and
14 majority position of the committee and which
15 shall be disseminated, at a minimum, to each
16 Federally recognized Indian tribe, tribal organi-
17 zation and urban Indian organization for com-
18 ment to the Commission; and
19 "(F) report regularly to the full Commis-
20 sion regarding the findings and recommenda-
21 tions developed by the committee in the course
22 of carrying out its duties under this section.
23 "(4) Not later than 18 months after the date
24 of appointment of all members of the Commission,
25 submit a written report to Congress containing a

1 recommendation of policies and legislation to imple-
2 ment a policy that would establish a health care sys-
3 tem for Indians based on the delivery of health serv-
4 ices as an entitlement, together with a determination
5 of the implications of such an entitlement system on
6 existing health care delivery systems for Indians and
7 on the sovereign status of Indian tribes.
8 "(e) ADMINISTRATIVE PROVISIONS.—
9 "(1) COMPENSATION AND EXPENSES.—
10 "(A) CONGRESSIONAL MEMBERS.—Each
11 member of the Commission appointed under
12 subsection (b)(1) shall receive no additional
13 pay, allowances, or benefits by reason of their
14 service on the Commission and shall receive
15 travel expenses and per diem in lieu of subsist-
16 ence in accordance with sections 5702 and 5703
17 of title 5, United States Code.
18 "(B) OTHER MEMBERS.—The members of
19 the Commission appointed under paragraphs
20 (2) and (3) of subsection (b), while serving on
21 the business of the Commission (including trav-
22 el time) shall be entitled to receive compensa-
23 tion at the per diem equivalent of the rate pro-
24 vided for level IV of the Executive Schedule
25 under section 5315 of title 5, United States

1 Code, and while so serving away from home and
2 the member's regular place of business, be al-
3 lowed travel expenses, as authorized by the
4 chairperson of the Commission. For purposes of
5 pay (other than pay of members of the Commis-
6 sion) and employment benefits, rights, and
7 privileges, all personnel of the Commission shall
8 be treated as if they were employees of the
9 United States Senate.
10 "(2) MEETINGS AND QUORUM.—
11 "(A) MEETINGS.—The Commission shall
12 meet at the call of the chairperson.
13 "(B) QUORUM.—A quorum of the Commis-
14 sion shall consist of not less than 15 members,
15 of which not less than 6 of such members shall
16 be appointees under subsection (b)(1) and not
17 less than 9 of such members shall be Indians.
18 "(3) DIRECTOR AND STAFF.—
19 "(A) EXECUTIVE DIRECTOR.—The mem-
20 bers of the Commission shall appoint an execu-
21 tive director of the Commission. The executive
22 director shall be paid the rate of basic pay
23 equal to that for level V of the Executive Sched-
24 ule.

1 "(B) STAFF.—With the approval of the
2 Commission, the executive director may appoint
3 such personnel as the executive director deems
4 appropriate.

5 "(C) APPLICABILITY OF CIVIL SERVICE
6 LAWS.—The staff of the Commission shall be
7 appointed without regard to the provisions of
8 title 5, United States Code, governing appoint-
9 ments in the competitive service, and shall be
10 paid without regard to the provisions of chapter
11 51 and subchapter III of chapter 53 of such
12 title (relating to classification and General
13 Schedule pay rates).

14 "(D) EXPERTS AND CONSULTANTS.—With
15 the approval of the Commission, the executive
16 director may procure temporary and intermit-
17 tent services under section 3109(b) of title 5,
18 United States Code.

19 "(E) FACILITIES.—The Administrator of
20 the General Services Administration shall locate
21 suitable office space for the operation of the
22 Commission. The facilities shall serve as the
23 headquarters of the Commission and shall in-
24 clude all necessary equipment and incidentals

1 required for the proper functioning of the Com-
2 mission.
3 "(f) POWERS.—
4 "(1) HEARINGS AND OTHER ACTIVITIES.—For
5 the purpose of carrying out its duties, the Commis-
6 sion may hold such hearings and undertake such
7 other activities as the Commission determines to be
8 necessary to carry out its duties, except that at least
9 6 regional hearings shall be held in different areas
10 of the United States in which large numbers of Indi-
11 ans are present. Such hearings shall be held to so-
12 licit the views of Indians regarding the delivery of
13 health care services to them. To constitute a hearing
14 under this paragraph, at least 5 members of the
15 Commission, including at least 1 member of Con-
16 gress, must be present. Hearings held by the study
17 committee established under this section may be
18 counted towards the number of regional hearings re-
19 quired by this paragraph.
20 "(2) STUDIES BY GAO.—Upon request of the
21 Commission, the Comptroller General shall conduct
22 such studies or investigations as the Commission de-
23 termines to be necessary to carry out its duties.
24 "(3) COST ESTIMATES.—

1 "(A) IN GENERAL.—The Director of the
2 Congressional Budget Office or the Chief Actu-
3 ary of the Health Care Financing Administra-
4 tion, or both, shall provide to the Commission,
5 upon the request of the Commission, such cost
6 estimates as the Commission determines to be
7 necessary to carry out its duties.
8 "(B) REIMBURSEMENTS.—The Commis-
9 sion shall reimburse the Director of the Con-
10 gressional Budget Office for expenses relating
11 to the employment in the office of the Director
12 of such additional staff as may be necessary for
13 the Director to comply with requests by the
14 Commission under subparagraph (A).
15 "(4) DETAIL OF FEDERAL EMPLOYEES.—Upon
16 the request of the Commission, the head of any fed-
17 eral Agency is authorized to detail, without reim-
18 bursement, any of the personnel of such agency to
19 the Commission to assist the Commission in carry-
20 ing out its duties. Any such detail shall not interrupt
21 or otherwise affect the civil service status or privi-
22 leges of the federal employee.
23 "(5) TECHNICAL ASSISTANCE.—Upon the re-
24 quest of the Commission, the head of a Federal
25 Agency shall provide such technical assistance to the

1 Commission as the Commission determines to be
2 necessary to carry out its duties.
3 "(6) USE OF MAILS.—The Commission may use
4 the United States mails in the same manner and
5 under the same conditions as Federal Agencies and
6 shall, for purposes of the frank, be considered a
7 commission of Congress as described in section 3215
8 of title 39, United States Code.
9 "(7) OBTAINING INFORMATION.—The Commis-
10 sion may secure directly from the any Federal Agen-
11 cy information necessary to enable it to carry out its
12 duties, if the information may be disclosed under
13 section 552 of title 4, United States Code. Upon re-
14 quest of the chairperson of the Commission, the
15 head of such agency shall furnish such information
16 to the Commission.
17 "(8) SUPPORT SERVICES.—Upon the request of
18 the Commission, the Administrator of General Serv-
19 ices shall provide to the Commission on a reimburs-
20 able basis such administrative support services as
21 the Commission may request.
22 "(9) PRINTING.—For purposes of costs relating
23 to printing and binding, including the cost of per-
24 sonnel detailed from the Government Printing Of-

1 fice, the Commission shall be deemed to be a com-
2 mittee of the Congress.
3 "(g) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated $4,000,000 to carry out
5 this section. The amount appropriated under this sub-
6 section shall not be deducted from or affect any other ap-
7 propriation for health care for Indian persons.

8 **"SEC. 815. APPROPRIATIONS; AVAILABILITY.**

9 "Any new spending authority (described in subsection
10 (c)(2)(A) or (B) of section 401 of the Congressional Budg-
11 et Act of 1974) which is provided under this Act shall
12 be effective for any fiscal year only to such extent or in
13 such amounts as are provided in appropriation Acts.

14 **"SEC. 816. AUTHORIZATION OF APPROPRIATIONS.**

15 "There is authorized to be appropriated such sums
16 as may be necessary for each fiscal year through fiscal
17 year 2012 to carry out this title.".

18 TITLE II—CONFORMING AMEND-
19 MENTS TO THE SOCIAL SECU-
20 RITY ACT

21 Subtitle A—Medicare

22 **SEC. 201. LIMITATIONS ON CHARGES.**

23 Section 1866(a)(1) of the Social Security Act (42
24 U.S.C. 1395cc(a)(1)) is amended—

1 (1) in subparagraph (R), by adding a semicolon
2 at the end;
3 (2) in subparagraph (S), by striking the period
4 and inserting "; and"; and
5 (3) by adding at the end the following:
6 "(T) in the case of hospitals and critical access
7 hospitals which provide inpatient hospital services
8 for which payment may be made under this title, to
9 accept as payment in full for services that are cov-
10 ered under and furnished to an individual eligible for
11 the contract health services program operated by the
12 Indian Health Service, by an Indian tribe or tribal
13 organization, or furnished to an urban Indian eligi-
14 ble for health services purchased by an urban Indian
15 organization (as those terms are defined in section
16 4 of the Indian Health Care Improvement Act), in
17 accordance with such admission practices and such
18 payment methodology and amounts as are prescribed
19 under regulations issued by the Secretary.".

20 **SEC. 202. INDIAN HEALTH PROGRAMS.**

21 Section 1880 of the Social Security Act (42 U.S.C.
22 1395qq) is amended to read as follows:

23 "INDIAN HEALTH PROGRAMS

24 "SEC. 1880. (a) ELIGIBILITY FOR PAYMENTS.—The
25 Indian Health Service (referred to in this section as the
26 'Service') and an Indian tribe or tribal organization, or

1 an urban Indian organization (as those terms are defined
2 in section 4 of the Indian Health Care Improvement Act),
3 shall be eligible for payments under this title, notwith-
4 standing sections 1814(c) and 1835(d), if and for so long
5 as the Service, Indian tribe or tribal organization, or
6 urban Indian organization meets the conditions and re-
7 quirements for such payments which are applicable gen-
8 erally to the service or provider type for which the Service,
9 Indian tribe or tribal organization, or urban Indian orga-
10 nization seeks payment under this title and for services
11 and provider types provided by a qualified Indian health
12 program under section 1880A.

13 "(b) PERIOD FOR BILLING.—Notwithstanding sub-
14 section (a), if the Service, an Indian tribe or tribal organi-
15 zation, or urban Indian organization, does not meet all
16 of the conditions and requirements of this title which are
17 applicable generally to the service or provider type for
18 which payment is sought, but submits to the Secretary
19 within 6 months after the date on which such reimburse-
20 ment is first sought an acceptable plan for achieving com-
21 pliance with such conditions and requirements, the Serv-
22 ice, an Indian tribe or tribal organization, or urban Indian
23 organization shall be deemed to meet such conditions and
24 requirements (and to be eligible for reimbursement under
25 this title), without regard to the extent of actual compli-

1 ance with such conditions and requirements during the
2 first 12 months after the month in which such plan is sub-
3 mitted.

4 "(c) DIRECT BILLING.—For provisions relating to
5 the authority of certain Indian tribes and tribal organiza-
6 tions to elect to directly bill for, and receive payment for,
7 health care services provided by a hospital or clinic of such
8 tribes or tribal organizations and for which payment may
9 be made under this title, see section 405 of the Indian
10 Health Care Improvement Act.

11 "(d) COMMUNITY HEALTH AIDES.—The Service or
12 an Indian Tribe or tribal organization providing a service
13 otherwise eligible for payment under this section through
14 the use of a community health aide or practitioner cer-
15 tified under the provisions of section 121 of the Indian
16 Health Care Improvement Act shall be paid for such serv-
17 ices on the same basis that such services are reimbursed
18 under State plans approved under title XIX.

19 "(e) TREATMENT OF CERTAIN PROGRAMS.—Not-
20 withstanding any other provision of law, a health program
21 operated by the Service or an Indian tribe or tribal organi-
22 zation, which collaborates with a hospital operated by the
23 Service or an Indian tribe or tribal organization, shall, at
24 the option of the Indian tribe or tribal organization, be
25 paid for services for which it would otherwise be eligible

1 for under this as if the health program were an outpatient
2 department of the hospital. In situations where the health
3 program is on a separate campus from the hospital, billing
4 as an outpatient department of the hospital shall not sub-
5 ject such a health program to the requirements of section
6 1867.

7 "(f) PAYMENT FOR CERTAIN NURSING SERVICES.—
8 The Service or an Indian tribe or tribal organization pro-
9 viding visiting nurse services in a home health agency
10 shortage area shall be paid for such services on the same
11 basis that such services are reimbursed under this title
12 for other primary care providers.

13 "(g) ALTERNATIVE METHODS OF REIMBURSE-
14 MENT.—Notwithstanding any other provision of law, the
15 Secretary may identify and implement alternative methods
16 of reimbursing Indian health programs for services reim-
17 bursable under this title that are provided to Indians, so
18 long as such methods—

19 "(1) allow an Indian tribe or tribal organization
20 or urban Indian organization to opt to receive reim-
21 bursement under reimbursement methodologies ap-
22 plicable to other providers of similar services; and

23 "(2) provide that the amount of reimbursement
24 resulting under any such methodology shall not be
25 less than 100 percent of the reasonable cost of the

1 service to which the methodology applies under sec-
2 tion 1861(v).".

3 **SEC. 203. QUALIFIED INDIAN HEALTH PROGRAM.**

4 Title XVIII of the Social Security Act (42 U.S.C.
5 1395 et seq.) is amended by inserting after section 1880
6 the following:

7 "QUALIFIED INDIAN HEALTH PROGRAM

8 "SEC. 1880A. (a) DEFINITION OF QUALIFIED IN-
9 DIAN HEALTH PROGRAM.—In this section:

10 "(1) IN GENERAL.—The term 'qualified Indian
11 health program' means a health program operated
12 by—

13 "(A) the Indian Health Service;

14 "(B) an Indian tribe or tribal organization
15 or an urban Indian organization (as those
16 terms are defined in section 4 of the Indian
17 Health Care Improvement Act) and which is
18 funded in whole or part by the Indian Health
19 Service under the Indian Self Determination
20 and Education Assistance Act; and

21 "(C) an urban Indian organization (as so
22 defined) and which is funded in whole or in
23 part under title V of the Indian Health Care
24 Improvement Act.

25 "(2) INCLUDED PROGRAMS AND ENTITIES.—
26 Such term may include 1 or more hospital, nursing

1 home, home health program, clinic, ambulance serv-
2 ice or other health program that provides a service
3 for which payments may be made under this title
4 and which is covered in the cost report submitted
5 under this title or title XIX for the qualified Indian
6 health program.

7 "(b) ELIGIBILITY FOR PAYMENTS.—A qualified In-
8 dian health program shall be eligible for payments under
9 this title, notwithstanding sections 1814(c) and 1835(d),
10 if and for so long as the program meets all the conditions
11 and requirements set forth in this section.

12 "(c) DETERMINATION OF PAYMENTS.—

13 "(1) IN GENERAL.—Notwithstanding any other
14 provision in the law, a qualified Indian health pro-
15 gram shall be entitled to receive payment based on
16 an all-inclusive rate which shall be calculated to pro-
17 vide full cost recovery for the cost of furnishing serv-
18 ices provided under this section.

19 "(2) DEFINITION OF FULL COST RECOVERY.—

20 "(A) IN GENERAL.—Subject to subpara-
21 graph (B), in this section, the term 'full cost re-
22 covery' means the sum of—

23 "(i) the direct costs, which are reason-
24 able, adequate and related to the cost of
25 furnishing such services, taking into ac-

1 count the unique nature, location, and
2 service population of the qualified Indian
3 health program, and which shall include di-
4 rect program, administrative, and overhead
5 costs, without regard to the customary or
6 other charge or any fee schedule that
7 would otherwise be applicable; and
8 "(ii) indirect costs which, in the case
9 of a qualified Indian health program—
10 "(I) for which an indirect cost
11 rate (as that term is defined in sec-
12 tion 4(g) of the Indian Self-Deter-
13 mination and Education Assistance
14 Act) has been established, shall be not
15 less than an amount determined on
16 the basis of the indirect cost rate; or
17 "(II) for which no such rate has
18 been established, shall be not less
19 than the administrative costs specifi-
20 cally associated with the delivery of
21 the services being provided.
22 "(B) LIMITATION.—Notwithstanding any
23 other provision of law, the amount determined
24 to be payable as full cost recovery may not be
25 reduced for co-insurance, co-payments, or

1 deductibles when the service was provided to an
2 Indian entitled under Federal law to receive the
3 service from the Indian Health Service, an In-
4 dian tribe or tribal organization, or an urban
5 Indian organization or because of any limita-
6 tions on payment provided for in any managed
7 care plan.

8 "(3) OUTSTATIONING COSTS.—In addition to
9 full cost recovery, a qualified Indian health program
10 shall be entitled to reasonable outstationing costs,
11 which shall include all administrative costs associ-
12 ated with outreach and acceptance of eligibility ap-
13 plications for any Federal or State health program
14 including the programs established under this title,
15 title XIX, and XXI.

16 "(4) DETERMINATION OF ALL-INCLUSIVE EN-
17 COUNTER OR PER DIEM AMOUNT.—

18 "(A) IN GENERAL.—Costs identified for
19 services addressed in a cost report submitted by
20 a qualified Indian health program shall be used
21 to determine an all-inclusive encounter or per
22 diem payment amount for such services.

23 "(B) NO SINGLE REPORT REQUIRE-
24 MENT.—Not all health programs provided or
25 administered by the Indian Health Service, an

1 Indian tribe or tribal organization, or an urban
2 Indian organization need be combined into a
3 single cost report.
4 "(C) PAYMENT FOR ITEMS NOT COVERED
5 BY A COST REPORT.—A full cost recovery pay-
6 ment for services not covered by a cost report
7 shall be made on a fee-for-service, encounter, or
8 per diem basis.
9 "(5) OPTIONAL DETERMINATION.—The full
10 cost recovery rate provided for in paragraphs (1)
11 through (3) may be determined, at the election of
12 the qualified Indian health program, by the Health
13 Care Financing Administration or by the State
14 agency responsible for administering the State plan
15 under title XIX and shall be valid for reimburse-
16 ments made under this title, title XIX, and title
17 XXI. The costs described in paragraph (2)(A) shall
18 be calculated under whatever methodology yields the
19 greatest aggregate payment for the cost reporting
20 period, provided that such methodology shall be ad-
21 justed to include adjustments to such payment to
22 take into account for those qualified Indian health
23 programs that include hospitals—
24 "(A) a significant decrease in discharges;

"(B) costs for graduate medical education programs;

"(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

"(D) payment for outlier cases.

"(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

"(A) on the full cost recovery basis provided in paragraphs (1) through (5);

"(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

"(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

"(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian Tribe or tribal organization; or

1 "(E) on the basis of any rate or methodol-
2 ogy negotiated with the agency responsible for
3 making payment.
4 "(d) ELECTION OF REIMBURSEMENT FOR OTHER
5 SERVICES.—
6 "(1) IN GENERAL.—A qualified Indian health
7 program may elect to be reimbursed for any service
8 the Indian Health Service, an Indian tribe or tribal
9 organization or an urban Indian organization may
10 be reimbursed for under section 1880 and section
11 1911.
12 "(2) OPTION TO INCLUDE ADDITIONAL SERV-
13 ICES.—An election under paragraph (1) may in-
14 clude, at the election of the qualified Indian health
15 program—
16 "(A) any service when furnished by an em-
17 ployee of the qualified Indian health program
18 who is licensed or certified to perform such a
19 service to the same extent that such service
20 would be reimbursable if performed by a physi-
21 cian and any service or supplies furnished as in-
22 cident to a physician's service as would other-
23 wise be covered if furnished by a physician or
24 as an incident to a physician's service;

1 "(B) screening, diagnostic, and therapeutic
2 outpatient services including part-time or inter-
3 mittent screening, diagnostic, and therapeutic
4 skilled nursing care and related medical sup-
5 plies (other than drugs and biologicals), fur-
6 nished by an employee of the qualified Indian
7 health program who is licensed or certified to
8 perform such a service for an individual in the
9 individual's home or in a community health set-
10 ting under a written plan of treatment estab-
11 lished and periodically reviewed by a physician,
12 when furnished to an individual as an out-
13 patient of a qualified Indian health program;
14 "(C) preventive primary health services as
15 described under sections 329, 330, and 340 of
16 the Public Health Service Act, when provided
17 by an employee of the qualified Indian health
18 program who is licensed or certified to perform
19 such a service, regardless of the location in
20 which the service is provided;
21 "(D) with respect to services for children,
22 all services specified as part of the State plan
23 under title XIX, the State child health plan
24 under title XXI, and early and periodic screen-

1 ing, diagnostic, and treatment services as de-
2 scribed in section 1905(r);
3 "(E) influenza and pneumococcal immuni-
4 zations;
5 "(F) other immunizations for prevention of
6 communicable diseases when targeted; and
7 "(G) the cost of transportation for provid-
8 ers or patients necessary to facilitate access for
9 patients.".

10 **Subtitle B—Medicaid**

11 **SEC. 211. PAYMENTS TO FEDERALLY-QUALIFIED HEALTH**
12 **CENTERS.**

13 Section 1902(a)(13) of the Social Security Act (42
14 U.S.C. 1396a(a)(13)) is amended—
15 (1) in subparagraph (B), by striking "and" at
16 the end;
17 (2) in subparagraph (C), by adding "and" at
18 the end; and
19 (3) by adding at the end the following:
20 "(D)(i) for payment for services described
21 in section 1905(a)(2)(C) under the plan fur-
22 nished by an Indian tribe or tribal organization
23 or an urban Indian organization (as defined in
24 section 4 of the Indian Health Care Improve-
25 ment Act) of 100 percent of costs which are

1 reasonable and related to the cost of furnishing
2 such services or based on other tests of reason-
3 ableness as the Secretary prescribes in regula-
4 tions under section 1833(a)(3), or, in the case
5 of services to which those regulations do not
6 apply, the same methodology used under section
7 1833(a)(3), and
8 "(ii) in the case of such services furnished
9 pursuant to a contract between a Federally-
10 qualified health center and a medicaid managed
11 care organization under section 1903(m), for
12 payment to the Federally-qualified health center
13 at least quarterly by the State of a supple-
14 mental payment equal to the amount (if any) by
15 which the amount determined under clause (i)
16 exceeds the amount of the payments provided
17 under such contract.".

18 **SEC. 212. STATE CONSULTATION WITH INDIAN HEALTH**
19 **PROGRAMS.**

20 Section 1902(a) of the Social Security Act (42 U.S.C.
21 1396a(a)) is amended—
22 (1) in paragraph (65), by striking the period;
23 and
24 (2) by inserting after (65), the following:

1 "(66) if the Indian Health Service operates or
2 funds health programs in the State or if there are
3 Indian tribes or tribal organizations or urban Indian
4 organizations (as those terms are defined in Section
5 4 of the Indian Health Care Improvement Act)
6 present in the State, provide for meaningful con-
7 sultation with such entities prior to the submission
8 of, and as a precondition of approval of, any pro-
9 posed amendment, waiver, demonstration project, or
10 other request that would have the effect of changing
11 any aspect of the State's administration of the State
12 plan under this title, so long as—
13 "(A) the term 'meaningful consultation' is
14 defined through the negotiated rulemaking
15 process provided for under section 802 of the
16 Indian Health Care Improvement Act; and
17 "(B) such consultation is carried out in
18 collaboration with the Indian Medicaid Advisory
19 Committee established under section 415(a)(3)
20 of that Act.".

21 **SEC. 213. FMAP FOR SERVICES PROVIDED BY INDIAN**
22 **HEALTH PROGRAMS.**

23 The third sentence of Section 1905(b) of the Social
24 Security Act (42 U.S.C. 1396d(b)) is amended to read as
25 follows:

1 "Notwithstanding the first sentence of this section, the
2 Federal medical assistance percentage shall be 100 per
3 cent with respect to amounts expended as medical assist-
4 ance for services which are received through the Indian
5 Health Service, an Indian tribe or tribal organization, or
6 an urban Indian organization (as defined in section 4 of
7 the Indian Health Care Improvement Act) under section
8 1911, whether directly, by referral, or under contracts or
9 other arrangements between the Indian Health Service,
10 Indian tribe or tribal organization, or urban Indian orga-
11 nization and another health provider.".

12 **SEC. 214. INDIAN HEALTH SERVICE PROGRAMS.**

13 Section 1911 of the Social Security Act (42 U.S.C.
14 1396j) is amended to read as follows:

15 "INDIAN HEALTH SERVICE PROGRAMS

16 "SEC. 1911. (a) IN GENERAL.—The Indian Health
17 Service and an Indian tribe or tribal organization or an
18 urban Indian organization (as those terms are defined in
19 section 4 of the Indian Health Care Improvement Act),
20 shall be eligible for reimbursement for medical assistance
21 provided under a State plan if and for so long as such
22 Service, Indian tribe or tribal organization, or urban In-
23 dian organization provides services or provider types of a
24 type otherwise covered under the State plan and meets
25 the conditions and requirements which are applicable gen-
26 erally to the service for which it seeks reimbursement

1 under this title and for services provided by a qualified
2 Indian health program under section 1880A.
3 "(b) PERIOD FOR BILLING.—Notwithstanding sub-
4 section (a), if the Indian Health Service, an Indian tribe
5 or tribal organization, or an urban Indian organization
6 which provides services of a type otherwise covered under
7 the State plan does not meet all of the conditions and re-
8 quirements of this title which are applicable generally to
9 such services submits to the Secretary within 6 months
10 after the date on which such reimbursement is first sought
11 an acceptable plan for achieving compliance with such con-
12 ditions and requirements, the Service, an Indian tribe or
13 tribal organization, or urban Indian organization shall be
14 deemed to meet such conditions and requirements (and to
15 be eligible for reimbursement under this title), without re-
16 gard to the extent of actual compliance with such condi-
17 tions and requirements during the first 12 months after
18 the month in which such plan is submitted.
19 "(c) AUTHORITY TO ENTER INTO AGREEMENTS.—
20 The Secretary may enter into agreements with the State
21 agency for the purpose of reimbursing such agency for
22 health care and services provided by the Indian Health
23 Service, Indian tribes or tribal organizations and urban
24 Indian organizations, directly, through referral, or under
25 contracts or other arrangements between the Indian

1 Health Service, an Indian tribe or tribal organization, or
2 an urban Indian organization and another health care pro-
3 vider to Indians who are eligible for medical assistance
4 under the State plan.

5 Subtitle C—State Children's Health
6 Insurance Program

7 **SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S**
8 **HEALTH INSURANCE PROGRAM.**

9 (a) IN GENERAL.—Section 2105(b) of the Social Se-
10 curity Act (42 U.S.C. 1397ee(b)) is amended—
11 (1) by striking "For purposes" and inserting
12 the following:
13 "(1) IN GENERAL.—Subject to paragraph (2),
14 for purposes"; and
15 (2) by adding at the end the following:
16 "(2) SERVICES PROVIDED BY INDIAN PRO-
17 GRAMS.—Without regard to which option a State
18 chooses under section 2101(a), the 'enhanced
19 FMAP' for a State for a fiscal year shall be 100 per
20 cent with respect to expenditures for child health as-
21 sistance for services provided through a health pro-
22 gram operated by the Indian Health Service, an In-
23 dian tribe or tribal organization, or an urban Indian
24 organization (as such terms are defined in section 4
25 of the Indian Health Care Improvement Act).".

1 (b) CONFORMING AMENDMENT.—Section
2 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B))
3 is amended by inserting "an Indian tribe or tribal organi-
4 zation, or an urban Indian organization (as such terms
5 are defined in section 4 of the Indian Health Care Im-
6 provement Act)" after "Service".

7 **SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH**
8 **INSURANCE PROGRAM.**

9 Title XXI of Social Security Act (42 U.S.C. 1397aa
10 et seq.) is amended by adding at the end the following:

11 **"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PRO-**
12 **GRAMS.**

13 "(a) IN GENERAL.—The Secretary may enter into
14 agreements directly with the Indian Health Service, an In-
15 dian tribe or tribal organization, or an urban Indian orga-
16 nization (as such terms are defined in section 4 of the
17 Indian Health Care Improvement Act) for such entities
18 to provide child health assistance to Indians who reside
19 in a service area on or near an Indian reservation. Such
20 agreements may provide for funding under a block grant
21 or such other mechanism as is agreed upon by the Sec-
22 retary and the Indian Health Service, Indian tribe or trib-
23 al organization, or urban Indian organization. Such agree-
24 ments may not be made contingent on the approval of the
25 State in which the Indians to be served reside.

1 "(b) TRANSFER OF FUNDS.—Notwithstanding any
2 other provision of law, a State may transfer funds to
3 which it is, or would otherwise be, entitled to under this
4 title to the Indian Health Service, an Indian tribe or tribal
5 organization or an urban Indian organization—
6 "(1) to be administered by such entity to
7 achieve the purposes and objectives of this title
8 under an agreement between the State and the en-
9 tity; or
10 "(2) under an agreement entered into under
11 subsection (a) between the entity and the Sec-
12 retary.".

13 Subtitle D—Authorization of
14 Appropriations

15 **SEC. 231. AUTHORIZATION OF APPROPRIATIONS.**

16 There is authorized to be appropriated such sums as
17 may be necessary for each of fiscal years 2000 through
18 2012 to carry out this title and the amendments by this
19 title.

20 TITLE III—MISCELLANEOUS
21 PROVISIONS

22 **SEC. 301. REPEALS.**

23 The following are repealed:
24 (1) Section 506 of Public Law 101–630 (25
25 U.S.C. 1653 note) is repealed.

1 (2) Section 712 of the Indian Health Care
2 Amendments of 1988 is repealed.

3 **SEC. 302. SEVERABILITY PROVISIONS.**

4 If any provision of this Act, any amendment made
5 by the Act, or the application of such provision or amend-
6 ment to any person or circumstances is held to be invalid,
7 the remainder of this Act, the remaining amendments
8 made by this Act, and the application of such provisions
9 to persons or circumstances other than those to which it
10 is held invalid, shall not be affected thereby.

○

The CHAIRMAN. Our panel will be John Callahan, assistant secretary, Management and Budget, Department of Health and Human Services; Melissa McNiel, Cherokee Nation of Oklahoma; Barbara Namias, director, Community Health Program, North American Indian Center in Boston; and Denis Turner, South California Tribal Chairmen's Association. If you would come to the floor.

Okay, if we could move on with this panel. We have a very limited time, as I mentioned to the first panel. And if our guests could be seated.

We'll start with John Callahan, assistant secretary, Management and Budget for the Department of Health and Human Services.

STATEMENT OF JOHN CALLAHAN, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CALLAHAN. Thank you, Chairman Campbell.

I have a full statement for the record.

The CHAIRMAN. Yes; we'll include that in the record. And if you would limit your comments to what this little light up here says, I would appreciate it.

Mr. CALLAHAN. Right. I want to thank you and Senator Inouye, the ranking member, for inviting us here today.

With regard to my oral statement, we want to commend the committee for moving this legislation forward. It basically is done in the process of tribal consultation, which as you know, the Department has taken the lead among many departments of having a strong tribal consultation process with regard to our budget and all our policies. So we commend you in that regard.

Our detailed statement indicates the Department's views on many of the provisions in S. 2526. Let me say at the outset, we are very supportive of a number of the provisions including the elevation of the Director of IHS, Dr. Trujillo, to the position of Assistant Secretary of Indian Health. And we also support many of the advances in the bill, particularly those dealing with diabetes funding, which the President has proposed to continue at a level of $30 million a year, as well as other authorizations for infectious disease and the modernization and establishment of epidemiological centers in Indian Country.

We're also encouraged by the provisions of the bill that talk about expanded authorizations for health services to urban Indians. We do know a number of urban Indians receive health services off the reservation, but there are many more that could receive those services, and we are supportive of many of the efforts that you're making in that regard.

There are a number of provisions in the bill, both in title III and title IV, that we feel need further consideration by the committee. In title III, in the area of facilities, the requirements to come forward with an annual facility plan, the additional burden that would cause, over and above the current priority list that the IHS develops, would be something that we'd have to look at carefully. But there are also further fiscal and feasibility analyses that have to be taken with regard to the loan guarantee and loan repayment programs, that are also proposed in the bill.

With regard to title IV, which is Medicaid and Medicare amendments, we would remind the committee that within the last 4 or 5 years, we have worked very closely together, with HCFA and IHS, to provide up to date and streamlined reimbursements for Medicare and Medicaid to IHS. This has resulted in an increase of $196 million flowing to IHS facilities.

We also had the proposal, as you know, which you've adopted, where there should be no premium and cost sharing for American Indian children under the SCHIP program. At the same time, we must make note that the public health service programs that are run by IHS and Medicare and Medicaid are in many ways distinctly different programs. Medicare and Medicaid have distinct rules about payments and eligibility. And we would like to work further with the committee about the problems that we see in that part of the bill.

Also we would say on negotiated rulemaking, as the committee knows, oftentimes that can be very constructive. But it has to be done in oftentimes a circumscribed manner, so that you will get to the end, you will have a consensus on negotiated rulemaking and not just have continuous meetings without any progress whatsoever. That would not be helpful either to the American Indian community or to the providers.

But let me end on a positive note, Chairman Campbell. We think that S. 2526 is a very, very positive step in the right direction. The Department and the Administration is committed to working with the committee in further consultation in those areas where we still have some questions. So we would like to thank you for your efforts in that regard.

[Prepared statement of Mr. Callahan appears in appendix.]

The CHAIRMAN. Well, thank you for that support.

I would remind you that we introduced this in May, as I remember. But it's my understanding that we sent you some paperwork on it to review the bill 10 months ago. And so if we do that again, I would hope you would get back to us earlier and give us some input on it.

And with that, oh, by the way, Dr. Trujillo, are you here as a resource person for Mr. Callahan?

Mr. TRUJILLO. Yes; I am.

The CHAIRMAN. All right, so we'll go ahead to Ms. McNiel, then.

STATEMENT OF MELISSA McNIEL, EXECUTIVE OFFICER, OFFICE OF PRINCIPAL CHIEF, CHEROKEE NATION

Ms. McNIEL. Thank you. Good afternoon, Senator Campbell, Senator Inouye and members of the committee.

I am Melissa McNiel, the executive officer of the Cherokee Nation. And I am here today to deliver Cherokee Nation's strong support for S. 2526. As you know, Cherokee Nation is the second largest tribe with over 213,000 tribal members. We were one of the first tribes to enter into a self-determination contract and a self-governance compact to deliver our health care services.

We operate six outpatient clinics with very limited resources. By operating our own health care system, we have been able to reduce the Federal bureaucracy, enhance local control and make efficiency

improvements which have allowed us to better meet the needs of our tribal members.

As I look around this room today and see many friends, I want to tell each of you that Cherokee Nation applauds your many efforts in addressing the unmet health care needs in Indian Country. You have once again done this through the introduction of this legislation, and we appreciate that.

We believe that this bill not only strengthens the tribes, but it also enables Indian Health Service and health agencies to better serve tribal members. We believe it helps the Federal agencies to become true partners, strong advocates and helpful resources for all tribes. We are pleased that the tone of this bill is that the health status objectives for Indians should be at least as good as the U.S. population as a whole.

The focus of my testimony today is title IV, which provides constructive ways for Indians to benefit from federally-funded health programs, in addition to the Indian Health Service. This is a critical concept, since the funding for Indian health programs does not meet the needs of Indian people.

And now I want to make a few specific recommendations on title IV. We recommend that section 409(c) include language to address the inequalities in health care funding, both in the Federal health system and the Indian health system. These inequalities are documented in the level of need funded study commissioned by Congress and published by Indian Health Service in December 1999.

We recommend that the premiums and copays for Medicare part B be waived in section 419(b)(2) to assure Medicare access for Indian elders.

Also because many Indian elders have lived their entire lives in areas of high unemployment and have not been able to meet the required quarter's work for Medicare eligibility, we recommend that all Indian elders be deemed eligible for Medicare. Medicare coverage for Indian elders is so critical because of the horrifying rate of diabetes. And to illustrate this point a little further, I want to tell you a quick story that our Chief Smith tells about his memorable encounter with diabetes and its effects.

Ruth was a tribal member who he would see from time to time and always enjoyed visiting with her. One time he saw her and she had a foot missing. He asked her why she had a foot missing, and she told him that the doctor had to cut it off due to her having diabetes. The next time he saw her, she had her leg missing. The next time it was the other foot, the other time the other leg.

Then he heard one day that she had passed away. Unfortunately, this story is the rule in Indian Country and not the exception. And we must do more to fight against this horrible disease.

We also recommend a clarification of the wording in section 423(a) to distinguish between public and private health care plans and the tribe's authority to bill the State directly for public health plans. We also recommend that reasonable costs be tied to a specific standard such as not less than the amount Medicare would pay IHS for the same service.

We also have a couple other recommendations in this title that are spelled out in the written testimony that I have submitted and won't go into for a lack of time.

But I want to make two brief statements on title V and title VI. About one-half of Cherokee Nation's tribal members live outside of our service area due to Federal policies that encouraged relocation by the BIA as well as the lack of employment opportunities in rural Oklahoma. We are very glad that the urban programs deliver health services to our urban Indian populations.

All of us in this room has tried to bring national attention and focus to the health status of Indian people. We have had some successes and some failures. We believe that the provisions in title VI will enable us to more effectively advocate for the unmet health care needs in Indian Country.

In conclusion, I just want to say that we believe S. 2526 simply allows Congress to fulfill promises made to tribes and enables tribes to operate their health systems more efficiently. Thank you for this opportunity to testify in support of this very important legislation.

[Prepared statement of Ms. McNiel appears in appendix.]

The CHAIRMAN. Thank you for those important comments on diabetes. I frankly don't know of an Indian family that hasn't been affected by it. You spoke of the lady with the foot that was amputated, my grandmother's stepbrother had his legs cut off three times. That might sound impossible to cut three times with just two legs, but that's what actually happened, is they cut one leg off below the knee, and then they had to cut the other one off, and that still didn't stop it, then they had to cut it off just below the thigh. So he lost his leg three times before he finally passed away.

So it has a devastating effect, not only on the person, but on the whole family, too. So I recognize that. Thanks for those comments.

And please wish our friend, Wilma Mankiller, we hope she's in good health and that retirement does have some virtues.

Ms. MCNIEL. Thank you.

The CHAIRMAN. Thank you.

Barbara, if you'd like to continue, please.

STATEMENT OF BARBARA NAMIAS, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Ms. NAMIAS. Good afternoon, Honorable Chairman and committee members. My name is Barbara Namias. I'm president of the National Council of Urban Indian Health. I'm a member of the St. Regis Mohawk Tribe and also the health director of the North American Indian Center of Boston.

On behalf of NCUIH and its 31 member organizations, I would like to express our appreciation for this opportunity to testify before your committee on the reauthorization of the Indian Health Care Improvement Act.

On March 8, 2000, the former president of NCUIH, Kay Culbertson, presented detailed testimony on the technical aspects of the Indian Health Care Improvement Act. I will not repeat that detailed analysis here. What I would like to do is address certain issues not addressed in the March 8 testimony. In particular, the absence of urban Indian in the Congressional policy statement for S. 2526, the definition of urban Indian and the status of the Oklahoma City Clinic and the Tulsa clinic.

Let me begin by saying that working with the National Steering Committee has been one of my best experiences in Indian Country. We were able to achieve an extraordinary level of consensus, proving that by working together, we can accomplish more than by working separately.

As a result, NCUIH strongly supports the recommendations of the National Steering Committee for the reauthorization of the Indian Health Care Improvement Act, which form the basis of S. 2526. We have raised, however, with the National Steering Committee, certain issues which relate to urban Indians which need to be addressed.

The first issue concerns a Congressional policy statement in S. 2526. The Indian Health Care Improvement Act currently provides that it is the policy of the United States to achieve the highest possible health status to both Indian and urban Indians. The law goes on to say that it is the intent of the Congress that the United States meet certain health objectives with respect to both Indians and urban Indians by the year 2000. This is current law.

For some reason, S. 2526 does not, however, include a reference to urban Indians in the equivalent paragraphs. Removing urban Indians from these important policy statements would imply that the Congress no longer considers the health status of urban Indians to be a national priority. We have been informed that this was an oversight. We strongly urge the restoration of urban Indian to section 3, subsection 1 and 2, of S. 2526.

The second issue relates to the definition of urban Indian was changed in a manner which would eliminate some Indians currently eligible for services at urban Indian programs. This has been explained as an unintended omission, and there has been general consensus on the National Steering Committee to restore the original language.

I would like to comment briefly on why the definition of urban Indian has, since initial passage of the Indian Health Care Improvement Act in 1976, been drafted to reflect the diverse makeup of the urban Indian community. Most urban Indians moved to the cities because of some Federal program or action, including one, the BIA relocation program, which relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians are still in the cities. They maintain their Indian identity even if in some cases they have been unable to re-establish ties, including formal membership with their tribes.

Two, the failure of Federal economic policies on reservations, which has forced many Indians to become economic refugees in the cities. Three, the termination of tribes, many of which have not yet been restored to recognition. Four, the marginalization of tribal communities such that they exist but are not federally recognized.

Five, Indian services in the U.S. military which brought Indians into the urban environment. And six, the General Allotment Act, which made some Indians U.S. citizens, many of whom lost their lands and had to move to nearby cities and towns. Seven, court sanctioned adoption of Indian children by non-Indian families. And eight, boarding schools.

Some of these Federal policies were designed to force assimilation and to break down tribal governments. Others may have been intended, at some misguided level, to benefit Indians but failed miserably.

The result of this course of dealing, however, is the same: The creation of an urban Indian community which is extremely diverse. In a 1976 report, the House noted that the Congress has a responsibility to assist urban Indians in achieving a life of decency and self-sufficiency, and has acknowledged that it is in part because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities.

Unlike the Indian population on reservations, most but not all urban Indians are members of federally recognized tribes. Yet they are all Indian. They are all recognized as Indians by their community, their circumstances are principally the result of Federal Indian policies. They are deserving morally and legally of support from the Federal Government in achieving the highest possible health status.

Finally, I would like to address the status of the Oklahoma City clinic and the Tulsa clinic. Both clinics would like to be established as permanent programs. However, section 512 of S. 2526 would only make the Tulsa clinic a permanent program. We believe that it is in the interest of the Oklahoma City urban Indian client population that the Oklahoma City clinic also be established as a permanent program.

The National Council of Urban Indian Health thanks this committee for its support for urban Indians. We also thank the committee for this opportunity to provide testimony on the reauthorization of the Indian Health Care Improvement Act.

[Prepared statement of Ms. Namias appears in appendix.]

The CHAIRMAN. Thank you for speaking up for urban Indians. Out of the approximately $2.3 billion IHS budget, about $27 million goes to urban Indians, and yet half the Indians in America live in urban areas. And I think most of us are aware that they're pretty under-served. So thanks for your comment.

Let me also apologize before I go any further to Melissa. Now I know why you're so knowledgeable about health care, because you helped formulate some of the language that's in this bill, and you were here on a fellowship last year. And I'm sorry, it's part of age, I guess, I apologize for that. Thanks for coming back to testify.

And Virginia, Ms. Hill, I had on my chart for people who are testifying a Denis Turner. Is there a connection? Are you speaking in his place?

Ms. HILL. Yes; I am.

The CHAIRMAN. Okay, that will be fine. Why don't you go ahead.

STATEMENT OF VIRGINIA HILL, SOUTHERN INDIAN HEALTH COUNCIL, INC.

Ms. HILL. He was unable to attend today, and I'm here with Ralph Goff, who is the chairman of the Campo Band of Kumei and also the president of the Southern California Tribal Chairmen's Association.

As you are aware, there are two Indian provisions in TANF, the first, equitable access to services that the Governor had to assure to, and the second being direct funding to tribes so they could run their own TANF programs. Currently, there are 21 tribal TANF programs and 20 pending, including the Torres Martinez in Southern California.

As you are aware, one of the major problems to providing any service in Indian Country is transportation. Tribal members must fill out one application for cash assistance on the reservation and then seek transportation to go to a county welfare office to apply for Medicaid and food stamps. What we're proposing is a one stop application by providing all welfare related services on the reservation.

It's just a short, a very short amendment that we're requesting. And the language is, Indian tribes that administer a tribal TANF program are authorized to determine eligibility for the Federal Medicaid program. We have support, there is a resolution that was passed by NCAI in 1998 in support of this effort, and also support letters from the Cherokee Nation, the Osage Nation, tribal chairmen and several others that were sent to Paul Moorehead's office.

Thank you very much.

[Prepared statement of Ms. Hill on behalf of Ralph Goff and Denis Turner appears in appendix.]

Senator INOUYE [assuming Chair]. I would like to ask a few questions if I may. I would like to preface this by indicating that I am not a mathematician. But according to the numbers and statistics provided this committee, there are 556 federally recognized tribes. That is correct, is it not?

And according to the report, 146 of these tribes receive health care services from the Indian Health Service, is that correct?

Mr. TRUJILLO. Of the 558 federally-recognized tribes, over one-half are presently contracting or compacting tribes. Those other tribes are handled through the Health Service.

Senator INOUYE. According to the numbers that we have, 431 tribes are self-governance or compact tribes, is that correct?

Mr. TRUJILLO. That's pretty close to the number. It's over one-half the federally-recognized tribes are right now self-governance and contracting tribes.

Senator INOUYE. One-half?

Mr. TRUJILLO. Over one-half at the present time.

Senator INOUYE. So the numbers that we have are not correct?

Mr. TRUJILLO. I'll have to make sure that those numbers are correct. Right now we're dealing with about 558 federally-recognized tribes. Over one-half of those tribes are now compacting or contracting. As you recognized, the Alaska tribes and native villages are also inclusive of that.

Senator INOUYE. Well, I will give the full numbers. According to the numbers, there are 556 federally-recognized tribes, 146 are served by IHS and they receive 58 percent of the budget; 431 are self-governance tribes, and they receive 42 percent of the budget; 431 receiving 42, 146 receiving 58.

And about 48 percent of the total population of American Indian-Alaska Natives reside in urban areas, about 1 million, for their health services we have set aside $27.8 million. Is that correct?

Mr. TRUJILLO. In regards to the funding that tribes get and also that those urban programs, there are approximately 34 urban programs across the United Sates, it is through title V. The majority of Indian Health Service funding does go to tribes and self-governance compacting, and to those tribes who wish to remain within the delivery system of Indian Health Service.

Senator INOUYE. I hope you will get together with the staff to clarify this. Because according to the written numbers we have here before me, that's what it says, and it just doesn't make sense that you would spend nearly 60 percent of the budget for 146 tribes and 40 percent of the moneys for 431 tribes. So will you have this clarified?

Mr. TRUJILLO. Yes; we will. But you have to remember that our funding is not per capita. It's based upon the various previous budget allocation. We also fund a number of facilities, the majority of Indian Health Service facilities, of course, are off, are not in the urban centers, but rather in reservations or remote sites such as Alaska or other places like that.

Senator INOUYE. I would like to get those numbers, also, because I would like to see if we are appropriately funding the self-governance tribes. It would appear from the numbers that have been provided to the committee that they are not appropriately funded.

Now, I do not want to come to that conclusion, but that is what the numbers tell me here.

Mr. TRUJILLO. Is this in regard to the self-governance tribes?

Senator INOUYE. According to—I will read this here. Self-governance tribes receive 42 percent of the IHS budget, which is $2.39 billion. And they manage 13 hospitals, 160 health centers, 3 school health centers and 236 health stations and native village clinics. Is that wrong?

Mr. TRUJILLO. That's approximately right. The majority of the self-governance tribes are also quite small in regards to numbers and also locations.

Senator INOUYE. And then it says here, and I am quoting, "direct health care services", that is what you provide, account for 58 percent of the IHS budget, and 36 hospitals, 58 health centers, 4 school health centers and 44 health stations. Fifty-eight percent for 146 tribes, 42 percent for 431 tribes.

Mr. TRUJILLO. Correct. Fairly correct. Within those direct service tribes, you also have the Navajo Nation, which is the largest tribe in the United States.

Senator INOUYE. So if you work it out, I want to get a better understanding. And also, the population figures. Because if these numbers are placed here without explanation, one would get the impression that a lot of money is being spent for bureaucracy, and it is not benefiting Indian Country.

Mr. TRUJILLO. We will give you appropriate numbers. In fact, the Indian Health Service has one of the lowest amount of administrative overhead in regards to the program base. The majority of funding does go to tribes, direct services, as well as urban programs. So your impression, or others' impression, could be a mistake in that regard.

Senator INOUYE. And the measure before us is a bill that was made by Indian Country, is that not correct? Who represents Indian Country here?

Ms. MCNIEL. I do.

Senator INOUYE. Are you satisfied with this measure?

Ms. MCNIEL. Well, as I stated in my testimony, the Cherokee Nation does support this bill strongly. We do have several recommendations that we submitted in our testimony.

Senator INOUYE. And Indian Country has had appropriate input in the drafting of this measure?

Ms. MCNIEL. As you know, there was a National Steering Committee that was put together that had appointed tribal representatives from the 12 areas of Indian Health Service. And it went through, they held several regional consultation conferences throughout the country where people could come and offer input.

So yes, it is a bill that has gone through tribal consultation, lots of input from the tribes.

However, nothing, you know, takes the place of a tribe having their sovereignty to have input on things. So with that said, yes, the bill has had lots of tribal input.

Senator INOUYE. Are you satisfied that the self-governance tribes are content with the funding provided? Are they happy with the funding?

Ms. MCNIEL. Well, of course, the funding for Indian Health care in itself is terrible. I don't know what other word to use. It's so under-funded. And I'd like to refer back to the study that I referred to in my comments on the level of need funded study, which was a study that was commissioned by Congress to look at the inequalities in Indian Health Care funding, not only in the Indian health care system, but also throughout the Federal system.

Indian health care funding, compared to the Federal system, a Federal employee receives health benefits that averages, I think it's about $2,800 per person. And Indian Health Service average is about $1,450 per person. And I just want to add, since I'm from Oklahoma, that Oklahoma is the lowest funded. And we're at $856 per person.

Senator INOUYE. I ask the question because I want it for the record. I am well aware of the discrepancies and the unfairness and the inequity. But we need it for the record here.

I know for example that the doctors in the Public Health Service are paid less than Defense Department doctors or Veterans Administration doctors. And their work is just as valuable, if not more valuable, than many of those other physicians. So the inequity runs right through the whole system.

Ms. MCNIEL. Yes, sir.

Senator INOUYE. Are you satisfied that the services provided by self-governance tribes are just as good as those provided directly by IHS?

Ms. MCNIEL. Oh, absolutely. I personally think that self-governance tribes that deliver their own health care system provide better health care. And the reason I say that is that people tend to generalize tribes as Indian people. But every tribe is unique. And the health care needs of individual tribes are also unique.

And a tribe that delivers their own health care system can tailor and redesign their health care system to meet those unique needs of those individual tribal members.

Senator INOUYE. In general, do the professionals, such as physicians, in the self-governance program, receive pay equal to that of the public health officers?

Ms. MCNIEL. I'm not sure I can answer that in general. I think that, I want to say yes. And the reason I want to say that is because the quality of the self-governance, and I'm speaking on behalf of Cherokee Nation, because we are self-governance and deliver our own health care, that the quality of our providers is top, is rated at the top.

So I guess in general I would want to say yes, but I don't know that for a fact. I've not done an analysis of that.

Senator INOUYE. I have several questions, including those prepared by the chairman of the committee, which I would like to submit to all of you for your consideration and response.

So with that, on behalf of the chairman, I thank all of you. And with that, the hearing is adjourned.

[Whereupon, at 2:56 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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

Good afternoon. The committee will come to order. Today's hearing marks the third in a series of hearings considering S. 2526, the Reauthorization of the Indian Health Care Improvement Act of 1976 [act], legislation I introduced along with Senator Inouye earlier this year.

The 1976 act forms the legal cornerstone for the provision of health services to Indian people, and its importance cannot be overstated.

American Indians and Alaskan Natives continue to suffer the worst health status of any racial or ethnic group in America. As I have stated before, Native people suffer diabetes at a rate that is three times that of the general population and alcoholism and cancer at rates that are six times greater than the general population. The statistics are appalling, yet it must be recognized that the overall status of Indian health has vastly improved over the last 25 years, an improvement that can be largely attributed to the efforts of Congress, the tribes and the Indian Health Service operating together and pursuant to authorizations granted under this act.

First passed in 1976, the Indian Health Care Improvement Act has been reauthorized four times. The overall purpose of the act is twofold: No. 1, to address and minimize the health disparities among Native people in a coherent manner, and No. 2, to encourage and maximize the number of Native people involved and participating in health care delivery in Native communities.

Additionally, this reauthorization seeks to reaffirm key principles with the passage of this legislation. First, we recognize that federally provided health services for Native people are consistent with the unique legal and political Federal-tribal relationship. Second, we reiterate that a key Federal goal of the United States is to provide the quality and quantity of health resources necessary to elevate the health status of American Indian and Alaskan Native people to the level enjoyed by most Americans.

Finally, and consistent with long-standing principles of Indian self determination and self governance, we continue to stress the importance of American Indian and Alaskan Native participation, to the maximum extent possible, in the planning, management, and implementation of health services.

S. 2526 is the product of hundreds of hours of hard work and is the culmination of tireless efforts of Indian tribes, urban health centers and the Administration to develop a draft bill that provides flexibility in the operation of Indian Health programs yet ensures their effectiveness.

Our hearing today will focus on three important aspects of the reauthorization legislation: No. 1, title IV, which deals with third party billing, and serves as an important source of cash-flow for Indian Health Service operations and allows them stretch the Federal dollar further; No. 2, title V, which authorizes the provision of health services to urban Indians through a grant program to urban Indian organizations; and No. 3, title VI, which deals with the organizational structure of the Indian Health Service.

Important changes have been made to each of the titles of the bill we will discuss today. For instance, changes have been made to title IV which makes permanent and expands a demonstration program that allows tribes to collect reimbursements for Medicare and Medicaid directly from Federal sources, rather than continuing the current convoluted process which requires a tribe to send their billing through the IHS which, in turn, seeks reimbursement on the tribe's behalf.

Changes to title V would streamline the processes for grant applications and contracting, and expands authorizations for the provision of services by urban programs, including eligibility for diabetes grants and the operation of the community health representative program.

Title VI provides that the Office of the Director of the Indian Health Service shall be elevated to the position of Assistant Secretary for Indian Health within the Department of Health and Human Services, a change supported by this Committee, the tribes, as well as the Department. Title VI also provides for the establishment of an automated management information system.

These changes are far reaching in their implications and I am looking forward to hearing from our witnesses today.

As we all know, there are barely 25 days remaining in the 106th Congress and there is much work for this committee to do. It is my intention that the committee report this legislation in this Congress and lay the groundwork for its continued consideration in the 107th Congress. The comments we hear today will do much to further the development of S. 2526.

Prepared Statement of Hon. Byron L. Dorgan, U.S. Senator from North Dakota

Mr. Chairman, I want to thank you for convening this hearing on legislation to reauthorize the Indian Health Care Improvement Act [IHCIA]. As has been documented at the earlier hearings on this subject, there is a health care crisis occurring in Indian country. Native Americans are still 5.3 times more likely to die of tuberculosis, 4.4 times more likely to die of chronic liver disease and cirrhosis, 2.5 times more likely to die of diabetes, 3 times more likely to die in an accident, and nearly twice as likely to commit suicide.

It is vitally important that Congress address these problems as part of the reauthorization of the IHCIA, which is scheduled to expire on September 30 of this year. The IHCIA is the major Federal law governing the delivery of health care to Native Americans, and it authorizes funding for health service delivery, programs to help ensure an adequate supply of Indian health professionals, health care facility construction, and health services for urban Indians, among other things.

This is the third in a series of four hearings the committee has planned on reauthorization of the IHCIA. I'm pleased, Mr. Chairman, that you have agreed to let me chair the fourth hearing on this important subject, along with Senator Conrad, next Friday, August 4 in Bismarck, ND. This field hearing will focus on titles VII and VIII of the reauthorization legislation, as well as Native Americans' access to prescription drugs. I will submit a longer statement for the record at next week's hearing.

Thank you, again, Chairman Campbell for your work and leadership on this issue.

Prepared Statement of Charlie Curtis, President, NANA Regional Corporation, Inc.

My name is Charlie Curtis, and I am the president of NANA Regional Corporation, Inc., one of the 12 Alaska Native Regional Corporations created pursuant to the Alaska Native Claims Settlement Act for the natives of northwest Alaska. NANA has over 11,000 Inupiat shareholders.

One of NANA's goals as a native corporation is to provide job opportunities for its shareholders. NANA employs over 1,500 employees, many of whom are shareholders. Employees in full time, non-temporary positions receive benefits, including health insurance. NANA is self insured for health care benefits.

NANA has seen a significant increase in the cost of its health care benefits in the past several years as a result of rebilling by Indian and Native entities running health care facilities in Alaska under-funding agreements pursuant to the Indian Self-Determination and Education Assistance Act.

I have reviewed a copy of the testimony of Mr. Jacob Adams, president of Arctic Slope Regional Corporation, on S. 2526, which I understand has previously been provided to you. NANA agrees with the comments made by Mr. Adams. Like ASRC, NANA, and not the Federal Government, is being asked to pay for the health care

services of its Alaska Native shareholder employees. This result is not compatible with Congress' intent to provide, at the Federal Government's expense, health care services for Alaska Natives.

Accordingly, NANA supports the adoption of section 406(g) of S. 2526.

Thank you for the opportunity to comment.

PREPARED STATEMENT OF GREGORY E. PYLE, CHIEF, CHOCTAW NATION OF OKLAHOMA

Chairman Campbell, members of the committee, ladies and gentlemen: Thank you for the opportunity afforded the Choctaw Nation of Oklahoma to provide testimony before such a distinguished body on this vital piece of legislation.

The Choctaw Nation is located in the extreme southeast comer of Oklahoma. Our historical boundaries encompass 10½ counties. Our tribal enrollment exceeds 140,000 Choctaws and they are scattered throughout the United States and across international boundaries. Our health service population is over 40,000, treating primarily Choctaw, but our open door policy assures that we will see many of representatives of the 557 federally recognized tribes. Many of our people are poor, living well below the national standard. Three of the counties within the Choctaw Nation have the lowest income rates in Oklahoma. Quality health care provided by the Choctaw Nation is a necessity for the people in our service area. not a luxury. The majority of people that we serve have no other choice. We are their only access to health care.

We take much pride in the direction the Choctaw Nation is moving. On July 14, 1999, we opened a new hospital in Talihina, OK. We built this $28 million, 144,000 square foot, facility with Choctaw Nation dollars, not Federal dollars. We were trying to provide health care to our population in an old TB sanitarium, built in the 1930's. This was unacceptable to us. As you can see, the delivery of quality health care to our people is our first priority.

With this in mind, allow me to make comments on the proposed legislation. In the interests of expediting the committee's considerations, and making our comments as helpful as possible, I will be brief.

Title 1: Indian Health, Human Resources and Development.

Any health care system cannot function without trained and qualified health care providers. Title I attempts to bring that qualification responsibility to the local level, by increasing requirements for qualified personnel. This is the goal, and the requirements are good, if you live in an area that is attractive to professional people. However, attracting service providers is a large issue with us. While it is beautiful and scenic in the Choctaw Nation, it is a great distance to large cities and all those things that cities can provide. People at the top level of their professions gravitate toward the cities, with their social, economic and education advantages. Priorities must be established to assist locations, such as ours, who have difficulties in recruiting. Enhanced scholarship programs must be provided with service fulfillments increased for service in Health Professional Shortage Areas. This is not a new concept, but it seems to have fallen by the wayside. We hope the committee will consider it for this title.

Title II: Health Service.

The Choctaw Nation of Oklahoma was one of the first tribes to contract for all the Indian Health Services provided to its citizens (1985). In 1994, we entered into a title III, self-governance agreement and have been aggressively carrying out our own programs. We know that the Indian Health Service budget is woefully inadequate. We urge the Congress and the Administration to pay heed to our requests for increased funding in fiscal years 2001, 2002 and subsequent years. We particularly want to draw the committee's attention, again, to the disparity in the funding for Indian Health Services, when viewed from two perspectives: First, compared to the general population, and second, when looked at among IHS service areas. A recent study, conducted under the auspices of IHS and called the level of need funding study, estimated that IHS funding was less than 12 percent of the funding spent on a comparable group of non-Indian study subjects [subjects were substantially supported in health care by the Federal Government]. This severe underfunding means a lack of services for all Indian trust-responsibility recipients of the Federal Government. In addition, the level of need study found that some IHS service areas were receiving 2½ times the amount of funding other areas were receiving. Due to historical and other factors, the Oklahoma area is the lowest in per capita funding among all IHS service areas. We ask specifically that Congress urge the director, Indian Health Service, that any new funding, above and beyond the level in the cur-

rent appropriations cycle, be distributed under the methodology presented by the level of need funded workgroup.

Diabetes is an illness connected to Native American populations in a disportionate percentage. Diabetes is killing and disabling our Indian people at alarmingly increasing rates. Early onset of type II diabetes, for instance, is now showing up in children, a situation which did not exist just 20 years ago. Tribal programs must receive increased funding for diabetes. Funding must not be restricted and placed in a contracting status, such as in the 150 million dollars diabetes demonstration project. We are competent to spend the money appropriately. The level of funding for this disease should be increased, and the number of different services provided should be increased. In Oklahoma, for instance, the Choctaw Nation, in conjunction with the University of Oklahoma, is seeking funding for the establishment of a Registry, to aid in identification and early treatment of this condition. This registry could be replicated and expanded throughout the State. Early detection, and diabetes prevention programs for those determined to be at risk, are key to getting a handle on this silent killer of Native Americans.

Title III: Health Facilities.

The Choctaw Nation took the responsibility, and built, a new hospital. We were on the Indian Health Service facilities list. However, it would have been years before we would have been funded. Also, we were able to build our hospital for almost 20 million dollars less than the Indian Health Service had estimated. The Choctaw Nation has also built an ambulatory clinic at Pouteau, OK through the joint venture program with Indian Health Service. We all acknowledge that there will never be enough money appropriated to keep our hospital and clinics up to the profession's standards. We must be innovative, using programs such as joint venture. We ask Congress to work closely with tribes and the Indian Health Service in these efforts. We offer ourselves as examples of what can be done, and we assure the committee we will work with any other tribes who seek to benefit from our experiences.

Title IV: Access

Tribal programs which have used their own initiative to move forward into contracting and compacting have set the standard for Indian Health Service in billing and collecting for third party reimbursements. In the period of little or no budget increases, this is the life-blood of our health programs. The Choctaw Nation of Oklahoma is one of four tribal programs in a demonstration program that allows for direct billing from third parties. We ask that the Choctaw Nation of Oklahoma be allowed to retain that status. We also, would support opening participation in this demonstration project to any tribal program wishing to participate. For these reasons, we thank the committee for its actions on S. 406, a bill to accomplish these tasks, and promise to work for its passage in the House.

Title V: Health Services for Urban Indians.

The Choctaw Nation recognizes that Indian people do move to larger cities seeking employment and education. Section 512 has become a major divisive issue for tribes and urban programs in Oklahoma. The Oklahoma City Urban Center and the Tulsa Urban program have been in demonstration status for 7 years. Section 512 would make these two programs permanent and would place them outside the scope of Indian self-determination. This proposed action would set a precedent that is contrary to self-determination and Self-Governance for Indian tribes and their citizens, as well as with the intent of all other legislation concerning services for Indian people. Services and resources to support those services are tied to federally recognized tribes that have a reservation land base or a previously defined land base, which resulted from individual treaties between tribes and the United States.

The demonstration authorization of funding for Federal Urban Indian Health Services resources, outside the responsibility of tribes, establishes the precedent that any group of Indian citizens or and individual Indian can have Congress set them up in business independently without honoring the Federal/tribal government to government relationship. While the two demonstration projects in Oklahoma City and Tulsa have addressed health care needs, they are clearly absent of any input and/or participation of the tribal governments, which are authorized to represent the Indian citizens to whom they are providing services. Before any final action is taken on this section, we suggest field hearings in Oklahoma to address this issue.

Title VI: Organizational Improvements.

The Choctaw Nation supports the elevation of the Director of Indian Health Service to the level of Assistant Secretary.

Title VII: Behavioral Health.

The Choctaw Nation supports additional funds to assist our patients in the mental health and substance abuse arena. However, we do not support the regional treatment center concept for existing or expanded programs. Historically, in-patient treatment without intense participation by the families or those significant to the

patients have failed. Regional programs located 3 to 4 hours from patient homes are not workable, or accessible to other working family members. Dollars provided for these regional programs should be made available to local programs that are underfunded. These dollars must remain at the local level.

Conclusion.

Indian Health Service programs carry the major load for assuring a minimum quality of life for your constituents, and my constituents. The Choctaw Nation of Oklahoma is among the leaders in taking the responsibility for these programs and their administration onto tribal shoulders. The health care of its people is the first priority of the Choctaw Nation. I appreciate the opportunity to share my statements with the committee. Positive and ongoing dialog will make the relationship between the U.S. Government and our tribal government stronger.

Thank you

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

JOHN J. CALLAHAN

ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

HEARING

ON

S. 2526

THE INDIAN HEALTH CARE IMPROVEMENT ACT
REAUTHORIZATION BILL

July 26, 2000

STATEMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON
S. 2526 – TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT
TO REVISE AND EXTEND SUCH ACT

July 26, 2000

Mr. Chairman and Members of the Committee:

Good afternoon, I am pleased to testify today on behalf of the Secretary of the Department of Health and Human Services on this historic legislation, S.2526, the Indian Health Care Improvement Act Reauthorization of 2000. Today, I am accompanied by Dr. Michael Trujillo, Director of the Indian Health Service (HIS), Mr. Michel Lincoln, Deputy Director, Mr. Gary Hartz, Acting Director of the Office of Public Health, and Dr. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Office of Public Health.

Since Dr. Trujillo last testified before this Committee, the Department has continued to review and analyze this complex and expansive proposal as reflected in S. 2526. The Indian Health Care Improvement Act (IHCIA) was originally enacted in 1976 to provide additional guidance and authority for the programs of the federal government that deliver health services to American Indian/Alaska Natives. The reauthorization of this cornerstone authority provides an opportunity for all of us to revisit the original intent of this legislation, and examine the Act in light of the many changes that have occurred in the health care environment during the past 24 years.

The IHS has the responsibility for the delivery of health services to Federally recognized American Indian and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (ITU)-operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level, in partnership with the population served. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. And, the Department's responsibility is to uphold the Federal government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

The Tribal Steering Committee Draft bill, upon which S. 2526 was based, was submitted to Congress by tribes directly and does not necessarily represent the Administration's views on policies. The Tribal and urban Indian health care proposals now contained in this bill recommend the most sweeping changes in the history of the IHCIA. S. 2526 contains recommendations that require careful analysis to determine the full impact of the bill's many recommendations.

In drafting the bill, tribal and urban Indian representatives placed no parameters or limitations on changes that they might consider or recommend for the reauthorization of IHCIA. This bill includes new requirements for IHS by establishing new and expanded authorities, which will increase expectations and place additional pressures on IHS' ability to operate programs within

its limited appropriation. We have concerns that these expansions would detract from IHS' ability to carry out its mission of providing basic health care services to AI/ANs. Also, since many of the new provisions convert grants into programs available for tribal Self-Determination contracts and compacts, the associated Contract Support Costs could increase proportionately. The FY 2001 Budget included a historic $230 million increase for IHS. Even though this is the largest funding increase ever requested, IHS would not be able to implement these expanded authorities.

S. 2526 contains eight (8) titles that encompass most of the health related provisions in the existing IHCIA: Title I, Indian Health, Human Resources and Development; Title II, Health Services; Title III, Facilities; Title IV, Access to Health Services, Title V, Health Services for Urban Indians; Title VI, Organizational Improvements; Title VII, Behavioral Health Programs; and Title VIII, Miscellaneous. The Administration is in the process of reviewing the many new provisions proposed in the tribal draft legislation in the context of the President's Budget. We are not prepared today to provide the Committee with a formal position on this expansive legislation without completing a thorough review. We will share with you today our views to date on some of the provisions contained in S.2526.

Title I – Indian Health, Human Resources and Development

The purpose of this title is to ensure that Indian health programs have an adequate supply of trained professionals able to provide culturally appropriate care. In order to achieve this goal, Title I includes provisions for the education and training of health care professionals. Many

provisions in the existing statute are proposed to be amended to accommodate the rapid pace of change in the health fields in future years. We note that Sec. 105 – Indian Health Professions - combines two separate scholarship programs into one section. Under the existing statute, Sec. 104 contains the Indian Health Service Scholarship Program and Sec. 120 contains the Matching Grants program. These two programs are separate in their administration and we would recommend they remain separate in the reauthorization of this provision.

Title II: Health Services

A number of provisions in Title II of the bill will assist in our efforts to reduce unnecessary disease and injury and raise Indian health to the highest possible level. There are many health care priorities in Indian Country, but effective prevention and treatment of diabetes and its related complications must rank among the highest. Sec. 204 of the bill would institutionalize the progress we are making with the diabetes program funded under the Balanced Budget Act of 1997, by establishing an ongoing national program within the IHCIA. This would be comparable to the President's proposal to amend the diabetes program in the Balanced Budget Act to continue funding for this important program. Sec. 212 would update and expand our tuberculosis program to focus more broadly on all communicable and infectious diseases.

Section 224(a) clarifies that patients receiving contract health services (CHS) authorized by the Service will not be liable for payment of charges or costs associated with provision of those services. This protection, together with additional protections in Title IV, would provide greater peace of mind for Indian patients who worry about dunning letters and damage to their credit because of CHS provider attempts to recover payments from them as well as from the Service.

Title III: Facilities

Sec. 301(a)(2) provides for newly constructed or renovated facilities, whenever practicable, to meet the construction standards of any nationally recognized accrediting bodies, not just JCAHO. This provision recognizes the expanding number of accrediting bodies; however, the Secretary does not recognize all of them for the various provider types they accredit. Because it appears as though the intent is to assure that construction and renovation funds maximize the likelihood of the facility being able to collect Medicare and Medicaid payments, it may be more appropriate to revise this provision of the bill to reflect that intent.

S. 2526 greatly expands agency program reporting requirements. We have general concerns about the overall reporting burden placed on IHS because it could require the diversion of resources from other much needed programs, including patient care, facility maintenance and other critical areas of the IHS programs. In addition, of concern is the new provision in Sec. 301(c) that would require the Secretary to report annually on the needs for health care facilities construction, including the renovation and expansion needs of existing facilities. While the first year report to Congress does not require consultation with Tribes, IHS would need to develop a baseline description of existing facilities and determine the need based on existing programs, facility conditions, facility efficiency and other factors.

Section 303(b) eliminates applicability of Davis Bacon wage rates for construction of Indian Health Service facilities. The Administration has significant concerns about this provision. The Administration is firmly committed to maintaining the important worker protections provided by

the Davis-Bacon Act which applies to workers employed by contractors and subcontractors performing on Federal or Federally-assisted construction projects.

Sec. 310 provides new authority for joint ventures between IHS and Tribes as an alternative to the long wait on the IHS facilities construction priority list. This proposed authority could assist the IHS and Tribal health programs in meeting the construction needs of facilities, which average 30 years of age, and maintenance and repair of many of the facilities in Indian country. Before moving ahead on any new Joint Venture projects in the future, IHS will need to examine the following issues: a) find a way to integrate and prioritize joint ventures with the IHS Facilities Construction Priority Lists; b) ensure that long term costs associated with staffing and operations are consistent with IHS standards for providing health care facilities and services to Federally Recognized American Indians and Alaska Natives can be accommodated by future funding levels; and, c) assure the funding committed to Joint Venture projects addresses priority needs for health care facilities and the delivery of health care services with the highest relative need.

Title IV: Access to Health Services and Conforming Amendments to the Social Security Act

In many respects, the changes in Title IV are the most far-reaching changes in the bill, both for the IHCIA and for the Social Security Act. We currently do not have cost estimates for this bill. In addition, we have not thoroughly assessed every provision for administrative feasibility and consistency with the President's Budget. I will highlight some provisions in this title.

Many of the changes in Title IV and conforming amendments to the Social Security Act focus on provider payment issues. Previous amendments to the IHCIA and the Social Security Act allow I/T/Us to bill Medicare and Medicaid in certain, limited ways and were intended to provide access to additional funds to supplement, not replace the IHS appropriation. Since those earlier amendments, both the general health system and Indian health have changed dramatically.

It is important to remember that there are fundamental differences between public health programs like IHS and many other HHS health programs, and health insurance programs like Medicare and Medicaid. Public health programs generally have limited funds, but they have broad discretion on how those funds may be used. Exactly the opposite is the case with Medicare and Medicaid, which are health insurance programs that guarantee payment with unlimited Federal funds, but place their limits on both the type of benefits and the categories of individuals for which those funds can pay. It is not surprising that IHS and HCFA programs, starting with such basic differences, have developed some incompatibilities.

Title II, sec. 203 adds a number of detailed provisions for a new provider type called a Qualified Indian Health Program (QIHP), for I/T/Us that want to participate in Medicare and Medicaid. The QIHP provisions contain a number of exceptions to the usual coverage, payment, and other rules for those programs. While creation of an Indian-specific provider type could address problems Indian providers face, the proposed QIHP is extremely complex and would present a number of difficulties in its administration.

Similarly, sec. 423 sets out a series of managed care payment rules and exceptions which may have unintended adverse consequences. In a growing number of States, health is dominated by managed care. Exempting Indian health from such systems could leave Indian providers and their patients without access to the significant advantages of increased benefits and care coordination common to such managed care systems. A simpler and more effective approach needs to be developed to address these issues.

Some proposed solutions in the bill are broader than necessary to address the underlying problems. For example-we understand that some people have read the current Emergency Medical Treatment and Active Labor Act (EMTALA) to require that Indian clinics transport emergency patients to their parent hospital even when an appropriate transfer to a closer hospital is warranted. As HCFA stated in its recent regulation concerning provider-based status, HCFA does not actually read EMTALA this way. We believe the problem could be addressed by some targeted technical assistance to Indian facilities on their responsibilities under EMTALA. In any case, it is unnecessary and perhaps unwise to exempt Indian clinics from the very important EMTALA patient protections, as Title II, sec. 202(e) proposes.

We have concerns with several other provisions in Title IV, including the following issues.

100% Reimbursement to States

Several provisions of the bill would extend the 100% Federal matching rate to States for

additional Medicaid and SCHIP services to AI/ANs. This would increase Federal program and related administrative costs.

Requirement on Medicare to reimburse for all non facility-based services

This provision would require Medicare to reimburse for all non facility-based services (e.g., home health, community-based care, ambulance services, physicians, DME, lab) provided by IHS providers. Currently, the Medicare statute requires HCFA to reimburse IHS for facility-based services (e.g., hospitals and SNFs). This would add significant new costs to the Medicare program.

Improving Access of Indian Beneficiaries to Medicare, Medicaid, and SCHIP

Sec. 419 proposes to waive Medicaid and SCHIP premiums and Medicare, Medicaid, and SCHIP cost sharing. The Administration is on record supporting waiver of premiums and cost sharing for Indian beneficiaries in SCHIP. The Medicare late enrollment penalty is necessary for an insurance program like Medicare to avoid the negative economic consequences of "adverse selection" where individuals do not enroll or pay premiums until they are ill with costly health conditions. A statutory waiver of the Medicare late enrollment penalty, therefore, is undesirable and unnecessary given administrative actions, and provisions elsewhere in the bill, that will encourage low-income Indian elders and persons with disabilities to enroll in Medicaid, which will pay Medicare premiums for them.

Consultation

Many sections of S. 2526 have tribal consultation requirements. We are concerned that these added responsibilities would stretch our resources at the expense of other programmatic responsibilities. Tribal consultation has been an important priority for this Administration. In HHS, we appreciate the value of consultation and are increasingly involved with Tribes in this process. However, we have some concerns about the specific manner in which Section 414(a) of S. 2526 would require consultation to occur. This provision requires consultation, as defined in Executive Order 13084 of May 14, 1998, to be held with Indian Health Service, Tribes and Urban Indian Health Programs (I/T/U's) prior to HCFA adopting *any* policy or regulation. Similar language in section 514 requires all Health and Human Services agencies to consult with urban Indian organizations prior to taking any action, or approving any action of a state, that may affect urban Indians or urban Indian organizations. While we value meaningful consultation on matters relevant to tribes and ITU providers, we believe these sections of the bill could be improved by providing for a process that more specifically identifies regulations and policies relevant to Tribes, *I/T/U* providers and urban Indians. In addition, reference to a particular Executive Order may be impractical if it is superseded or rescinded. It may be more effective to use language in the current Department of Health and Human Services (HHS) consultation policy.

Negotiated Rule Making

HHS agencies have had first-hand experience with the positive contributions of negotiated rule making. Section 553 of 5 U.S.C. Negotiated Rule Making, lists factors to be considered in

determining whether or not to use the negotiated rule making procedure. These factors include: a limited number of identifiable interests that will be significantly affected by the rule as well as reasonable likelihood that a committee can be convened with a balanced representation of persons who are willing to negotiate in good faith to reach agreement by consensus on the proposed rule within a fixed period of time. Where such factors are present, negotiated rule making can be very helpful in structuring a process through which relevant stakeholders participate constructively in developing a recommended rule. However, S. 2526 would require negotiated rule making in many of its provisions. For example, Section 414 (b) would require HCFA to use the negotiated rule making for the development of all regulations to implement provisions contained in Title IV that would amend the Social Security Act, and section 802 would require the Secretary to use negotiated rule making for all regulations to implement this Act.

Negotiated rule making is very resource intensive for both Federal and non-Federal participants, and may not be the most effective way to obtain necessary I/T/U provider input in the development IHCIA rules and regulations. We would recommend instead utilizing the consultation to identify areas in the reauthorization legislation where the negotiated rule making process would be appropriate for the development of regulations.

Additionally, Section 802(b) of the bill limits membership on negotiated rule making committees to Federal and Tribal representatives. For committees to implement provisions related to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP), it would be

important to include representatives of State agencies charged with implementing these programs, as well as other key provider and beneficiary interests. This would increase opportunities for Tribal and other Indian representatives to build consensus and support in the development of final rules to implement the bill's various provisions.

Other General Comments

In a number of sections in the bill, for example Section 103(a), the word "grant" is stricken and replaced by "make funds available." Deleting the word "grant raises" the concern that the Department's regulations at 45 CFR might not apply to any funding agreements under this bill. We suggest using the term "grant" where appropriate throughout the bill.

There are also several sections, for example section 516(a), where the Secretary is directed to pay for services that are not presently provided. In the absence of additional appropriations, complying with these provisions would require funding reductions for existing services that are no less necessary. We suggest that any requirement for the provision of new services be subject to the availability of appropriations.

We have not had an opportunity to field cross-agency concerns over many exemptions for tribes, tribal organizations, and urban organizations on broader long-standing Federal policies, including the Davis-Bacon Act, the Buy American Act, Section 117 of the Internal Revenue Code of 1986, the Federal Reports Elimination Act of 1998, and the Anti-Deficiency Act.

Title V: Health Services for Urban Indians

Title V authorizes the IHS to assist in meeting the health care needs of American Indians and Alaska Natives living in urban areas. Currently, urban Indian health programs serve approximately 149,000 urban Indians in 34 cities through the country. We estimate that over 350,000 urban Indians are eligible for services. With a few exceptions, funding authority for urban Indian health is specifically limited to Title IV and Title V. All other references to urban Indian health found in the other titles of the bill address areas such as consultation, rule making planning or reporting only.

S. 2526 would streamline the process for contracting and making grants to urban Indian organizations. While we support a streamlined process for contracting and grant making, we do have concerns with the elimination of certain criteria in the existing statute in S. 2526. In the existing IHCIA, Sec. 503 of Title V requires that the urban organization successfully undertake certain activities as a condition to entering into a contract with IHS for the provision of health care and referral services for urban Indians residing in the particular urban center. The elimination of these criteria would be appropriate for on-going urban Indian contractors, but for new contractors, it would be important to retain those requirements as conditions for awarding a contract or grant.

Title V also contains new authority for the establishment of an Urban Indian Health Care Facility Revolving Loan Fund to provide guaranteed loans to urban Indian health contractors and grant recipients for construction, renovation, expansion, or purchase of health care facilities. In

addition, Title V authorizes the extension of Federal Tort Claims Act coverage for urban Indian health programs. These new provisions could assist urban Indian health programs, however, they would require additional resources and we would need to assess how these new provisions fit into the Administration's priorities for Indian health.

Title VI: Organizational Improvements

Sec. 601(a)(2) provides for the elevation of the Director of the IHS to Assistant Secretary for Indian Health. The Administration has presented testimony before this committee in support of S. 299, the stand-alone bill that contains the identical provisions of Sec. 601. We believe this provision would provide a stronger coordination and advocacy role in budget and policy matter related to Indian health.

In addition, Sec. 602 (d) would authorize the Secretary, acting through the Assistant Secretary for Indian Health to enter into contracts, agreements, and joint ventures with other Federal agencies, States, and private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities. The Administration promotes the partnership and collaboration with our sister Federal agencies in a variety of areas related to Indian health in order to maximize our resources and involvement with other Federal programs in the provision of health related services to AI/ANs.

Title VII: Behavioral Health Programs

Title VII includes many sections that were transferred from Title II, Health Services, in the

existing IHCIA. This title includes major revisions, specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. Where appropriate, the term tribes, tribal organizations and Indian organizations are referenced in addition to IHS.

A broad range of behavioral health services is described under "continuum of care." Several related sections were moved from Title VIII in the existing IHCIA, including the section related to Fetal Alcohol Syndrome and Child Sexual Abuse. Demonstration programs were eliminated and replaced with language authorizing programs for Indian tribes and tribal organizations. A new section would authorize the establishment of at least one inpatient psychiatric treatment facility per IHS Area. These new centers would be funded on a similar basis as the Regional Youth Treatment Centers authorized in the existing IHCIA We are concerned about the feasibility of establishing at least one inpatient psychiatric treatment facility per Area. The cost could be prohibitive and there could be difficulties in recruiting and retaining specialized staff, as well as the complexities of starting a new provider type.

Title VIII: Miscellaneous

Section 813 would deem tribal contractors and compactors as ordering agents of the Indian Health Service. We recommend that this language be revised to be consistent with the language in H.R. 1167 that authorizes tribal access to Federal sources of supply only for the purposes of carrying out an agreement under the Indian Self-Determination and Education Act.

This title establishes a National Bi-Partisan Commission on Indian Health Care Entitlement. This commission would be comprised of members of Congress, Tribal leaders, and Urban Indian health leaders to study the desirability and feasibility of making Indian health an entitlement. While many Tribal leaders and Indian people believe that the provision of health care to them should be a legal entitlement, there are many questions regarding the ramifications, including the costs, of such an entitlement.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to discuss the reauthorization of the Indian Health Care Improvement Act. We will continue to analyze the implications of this expansive legislation and will be happy to work with the committee and the Indian Health Care National Tribal Steering Committee to address the Administration's concerns. As we move into the new millennium, we must acknowledge and fulfill the long overdue obligation to advance the health status of Indian people to the highest possible level. We will be happy to answer any questions that you may have.

TESTIMONY OF MELISSA MCNIEL
EXECUTIVE OFFICER, OFFICE OF PRINCIPAL CHIEF
CHEROKEE NATION
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON S. 2526
A BILL TO REAUTHORIZE THE
INDIAN HEALTH CARE IMPROVEMENT ACT
July 26, 2000

Good afternoon Mr. Chairman and Members of the Committee, my name is Melissa McNiel, and I am the Executive Officer in the Office of the Principal Chief for the Cherokee Nation. I appear here at the request of Principal Chief Chad Smith to deliver the Cherokee Nation's strong support for S. 2526, the Indian Health Care Improvement Act Reauthorization of 2000. With me are Cherokee Councilwoman Stephanie Wickliffe and Dr. Mim Dixon, Executive Director, Health Services for the Nation.

The Cherokee Nation represents over 213,000 tribal citizens, nearly half of whom live within our 7,000 square mile jurisdictional area. The Cherokee Nation has approximately 1,800 tribal employees (making it one of the largest employers in Northeast Oklahoma), about one-third of whom work in the Nation's health services division.

The Cherokee Nation was one of the first tribes in the United States to execute a self-determination contract under the original 1975 Indian Self-Determination Act and was also the very first tribe to execute a self-governance agreement under Title III of that Act. Since 1994 all of our self-determination programs have been administered under self-governance compacts with the Department of Health and Human Services (DHHS) and the Department of the Interior (DOI).

Under our self-governance compact with DHHS the Cherokee Nation operates six rural outpatient clinics with very limited resources. The Cherokee Nation also operates the inpatient and outpatient contract health services associated with Indian Health Service's (IHS) W.W. Hastings Hospital in Tahlequah, Oklahoma.

The Cherokee Nation applauds this Committee's effort to ensure that the many positive benefits of the Indian Self-Determination Act apply with full force to Indian health care. The President, Secretary Shalala, and Congress, including this Committee, have all recognized that the

federal policy of tribal self-determination and self-governance has been the most successful federal Indian policy in our Nation's history. Congress has an important role to play in protecting and preserving these policies. You have once again done this through the introduction of this legislation.

Twenty-five years ago the Cherokee Nation began the process of self-determination contracting to operate IHS programs to streamline, redesign and enhance federal services for our people. As a result of our vision and our determination, the Cherokee Nation has succeeded in substantially reducing the federal bureaucracy, enhancing local control and making vast improvements in the efficiency of these programs for the benefit of our people.

As you, Senator Campbell, stated in your Introduction Statement for this bill, it "re-affirms the core principles that were part of the 1976 legislation: (1) that federal health services are consistent with the unique federal-tribal relationship; (2) that a goal of the U.S. is to provide the quantity and quality of services to raise the health status of Indians, and (3) that Indian participation in the planning and management of health services should be maximized."

We strongly support the provisions of S. 2526 to continue this self-determination effort. This reauthorization not only strengthens the tribes, but also enables the IHS and other health agencies to better serve tribal members. These federal agencies will become stronger, not weaker, once they stop resisting the natural desire of Indian tribes to govern themselves and start figuring out ways to become true partners, strong advocates and helpful resources for all tribes.

The reauthorization of this Act was conducted under the Tribal Consultation Policy. Indian Health Service convened a Roundtable in June 1998 to begin the discussion of the reauthorization and to give guidance to the consultation process, which included all stakeholders, IHS/Tribes/Urban (IHS).

Coordinators from the 12 IHS Areas formed workgroups of stakeholders and National Indian Health Board representatives. These meetings were to inform the stakeholders about the reauthorization process, and provide opportunities to discuss and reach consensus on recommendations for the Act.

Four regional consultation meetings were held to provide further opportunities for the stakeholders to provide input, share recommendations from the Areas, and build consensus among

participants for a unified position. The final report entitled "**Speaking with One Voice**" identified areas of consensus and differences.

The IHS Director convened a National Steering Committee (NSC) to be responsible for the final drafting of the report on the IHCIA recommendations. The NSC is composed of one elected and one alternate tribal representative from each of the 12 Areas, a representative from the NIHB, National Council of Urban Indian Health (NCUIH), and the Self-Governance Advisory Committee. During the course of the 4 meetings, this group's tribal responsibility evolved from compiling a final report of recommendations to the drafting of the actual IHCIA reauthorization bill language.

A National Forum, which was co-sponsored by this Committee, provided time for tribal leaders, urban health representatives, national organizations, related federal agencies and other friends of Indian health, to provide feedback on the draft of the IHCIA reauthorization bill.

With this bill being the product of what we consider to be true tribal consultation, we believe that it will improve the current health care delivery system in many positive ways, including local control and flexibility, and responsiveness to the health needs of Indian people.

We are very happy that this bill sets the tone by focusing on the health status objectives for Indians and by stating that they should be at least as good as the U.S. population as a whole.

Since today's hearing is to focus on Title IV, V, and VI, let me now speak briefly about each:

Title IV - Access to Health Services

Title IV provides some very constructive ways to assure that the American Indian and Alaska Native people benefit from Medicaid, Medicare, Child Health Insurance and other federally-funded health care programs in addition to the IHS delivery system. With a history of federal funding that is significantly below the needs of the American Indian populations, it is important the Indian health care delivery system maximize funding from these sources.

If health care for American Indians was treated as an entitlement, we would not have to talk about supplemental sources of funding. If Indian health care was treated as an entitlement, the federal funding would automatically be adjusted to accommodate population increases and inflation. However, this has not happened. Each year the inflation-adjusted per capita funding

for Indian health declines. So, we must have alternative sources of revenues. Even with Medicaid and Medicare and Child Health Insurance, the funding for personal medical services in the Indian health system is 40 percent less than the health care funding for federal employees. So the provisions in Title IV are essential to preventing the further deterioration of the Indian health care system.

As a whole, we support the provisions in this section; however, we also offer some suggestions for strengthening the language and concepts in Title IV.

Sec. 409. IHS, Department of Veteran's Affairs, and Other Federal Agency Health Facilities and Services Sharing

(c) Agreements for Parity in Services. We are pleased that Congress is considering parity in services in this section. However, there are other issues of parity that should also be considered in the reauthorization of the Indian Health Care Improvement Act.

The Level of Need Funded Study published in December 1999 established that the personal medical services funding for Indian health was only 60 percent of the comparable services for federal employees used as a benchmark. It also compared funding needs within the 12 Areas of the IHS. This study shows that the Oklahoma Area receives the least per capita funding of any Area in the IHS. The Oklahoma Area per capita funding is only $856, compared to an average of $1,495 for all Areas of the IHS, which is only 60 percent of the $2,980 needed to have parity with the federal employee health care benefits.

The Cherokee Nation is served by two of the most underfunded Service Units in the country. Just to bring these two Service Units up to the 60 percent average funding level for the entire IHS requires additional federal funding of $16.6 million for the Claremore Service Unit and $11.6 million for the Tahlequah Service Unit. Thus a total of $28.2 million dollars more in federal appropriations is needed just to bring the Cherokee Nation up to the IHS average of 60 percent of the personal medical service needs. To fully fund these two Service Units would take $66 million. We note that these two Service Units provide health care for 52,780 users, including some from other tribes.

So, we urge you to expand your consideration of parity issues somewhere in this legislation.

Sec. 419. Co-insurance, Co-payments, Deductibles and Premiums

(b) Exemption from Premiums

We think that the concept here is good. However, the provisions in paragraph 1 should also apply to Medicare in paragraph 2.

(2) Medicare Enrollment Premium Penalties

We certainly support the wording in this section, but we believe it does not go far enough to assure that Indian elders have access to Medicare. As with the previous paragraph, we believe that members of federally-recognized tribes should have their Medicare Part B premiums and co-pays waived. Furthermore, many Indian elders have lived their entire lives in areas of extremely high unemployment where they have been unable to work the required quarters in jobs that would qualify them for Medicare. We believe that all Indian elders should be deemed eligible for Medicare. This is especially important in relation to the high rate of diabetes and end stage renal disease for which Medicare coverage is essential.

Sec. 423. Provisions Relating to Managed Care

This section is extremely important in the current health care environment in which managed care is the dominant form of third party payment.

(a) Recovery from Managed Care Plans

We support the intent of this section, but we believe that the wording needs some clarification. While the right of recovery is an important concept, we think it applies specifically to private sector health plans. It is confusing to roll the private sector plans in with the public sector plans with regard to billing for off-plan services. We support the provision in paragraph (e) which states that the Indian health organizations "shall have the right to be paid directly by the State agency administering" Medicaid and Child Health Insurance Plans. Paragraph (a) could be

read to suggest that Indian health organizations would bill the plans rather than the states for these programs.

The wording "reasonable costs" is subject to interpretation. We think it should be tied to a specific standard, such as "not less than the amount Medicare would pay the IHS for the same service."

(g) Prohibition

This section addresses the default assignment of Indians to Medicaid and Child Health Insurance managed care plans. We think this section should be strengthened in two ways, which would provide access to culturally competent care:

1. If an American Indian does not choose a plan, the default assignment will be to an Indian health provider; and
2. If an American Indian does choose a plan, they can change their assignment to an Indian health provider without being subject to a lock-in period.

Sec. 425. Indian Advisory Committees

While we support the provisions in this section, we want to see a statement that the advisory committees do not replace the requirement for government-to-government consultation between HCFA and tribal governments.

(b) Indian Medicaid Advisory Committees

Because each state has a different Medicaid program, we endorse the concept of a separate Indian Medicaid Advisory Committee for each state where there is an Indian health system. However, we believe this legislation should stipulate that the tribes in each state shall be part of the decision-making to determine the membership structure of the state advisory committee, along the lines of negotiated rule-making.

Title II - Conforming Amendments to the Social Security Act

Our copy of the legislation has a second Title II at the end of the bill. Many of the provisions in this section relate to the financing issues in Title IV. Therefore, we would like to

take the opportunity to comment on portions of this section. Specifically, we want to add our strongest endorsement to the following sections:

Sec. 202 (e) Treatment of Certain Programs

This technical amendment to the Social Security Act that would allow tribes to bill Medicare for outpatient services has been needed for a long time. We urge you to act on it even before passage of the Indian Health Care Improvement Act.

Sec. 203. Qualified Indian Health Program

Using a payment method that provides for full cost recovery is necessary in the Indian health system because there is nowhere to shift costs. Very few patients who seek services from the Indian health care system have private health insurance. The IHS is so underfunded that it should not be asked to absorb the costs of providing services to beneficiaries of other federal programs.

Title V - Health Services for Urban Indians

This title establishes urban Indian health programs so that health care services are accessible to urban Indians. This title gives the Secretary of DHHS, through the IHS, the authority to enter into contracts or grants to urban Indian organizations to help these agencies with establishing and administering health programs.

Approximately one-half of the Cherokee Nation tribal members live outside of our service area due to federal policies that encouraged relocation by the BIA as well as the lack of employment opportunities in rural Oklahoma. These Indians should not be penalized for living in urban areas. Therefore, the Cherokee Nation supports the urban Indian programs, in general, and the enhancements made in Title V. Specifically, we would like to comment on two of the sections:

Sec. 516. Urban Youth Treatment Center Demonstration. With the erosion of the quality of life from alcohol and substance abuse, especially in Indian youth, the Cherokee Nation supports this section whole-heartedly. With Native communities being plagued by alcohol and

substance abuse, it is causing havoc on Native families across the country. Alcohol continues to be an important risk factor associated with the top three killers of Native youth: accidents, suicide, and homicide. Native Americans have higher rates of alcohol and drug use than any other racial or ethnic group. Eighty-two percent of Native adolescents have used alcohol, compared to 66 percent of non-Native youth. Indian youth face many challenges in the urban setting and for the urban Indian programs to offer culturally competent residential settings for urban Indian youth will be much more effective. New monies are needed to fund this effort as well as adequate funding for the Youth Regional Treatment Control, one of which is operated by Cherokee Nation.

Sec. 518. Grants for Diabetes Prevention, Treatment and Control. Diabetes continues to be a growing problem in many American Indian and Alaska Native (AI/AN) communities with rates increasing rapidly. Diabetes is an epidemic among AI/AN and has been identified as a top health problem in all areas of the IHS. AI/AN are at a risk of 231 percent greater for diabetes mellitus than the U.S. all races' population. Diabetes is a major cause of morbidity (such as blindness, kidney failure, lower-extremity amputation, and cardiovascular disease) and premature mortality in AI/AN. Diabetes is the leading cause of patient visit to Cherokee Nation clinics.

In 1996, an estimated 63,400 AI/AN who receive care from IHS had diabetes. The prevalence of diabetes increases with age and is greater among women than men. With these alarming rates of diabetes among AI/AN, Cherokee Nation supports all diabetes programs. Increased funding is needed for the prevention and treatment of diabetes throughout Indian Country.

Title VI - Organizational Improvements

Indians have tried for many years to bring the much needed national attention and focus on the health status of AI/AN. There have been many failed attempts, but with our perseverance we believe that one day we will be able to achieve our goals.

The Cherokee Nation believes that the provisions in this will assist in our endeavors.

Sec. 601. Establishment of the IHS as an Agency of the Public Health Service. This section addresses the establishment of the IHS as an agency of the PHS. It covers the appointment of the Assistant Secretary of Indian Health by the President and confirmed by the Senate.

There is no doubt that in the competition for a priority in the federal budget; the IHS is losing out each year. Tribal governments have long supported elevating the status of the IHS Director in the hope that greater stature will enable IHS to more effectively advocate for the health needs of AI/AN. This is an accomplishment that will not only decrease the bureaucratic overhead, but will help Indian Country reach its health care goals.

This elevation is needed in order to further the unique government-to-government relationship between Indian tribes and the United States, facilitate advocacy for the development of Indian health policy, and promote consultation on matters related to Indian Health. This elevation will not only provide the necessary leadership within the Administration on Indian health issues, but will bring the much needed focus, national attention, and parity to the devastating health care status of AI/AN.

Sec. 602. Automated Management Information System. This section authorizes the Secretary through the Assistant Secretary of Indian Health to establish an automated management information system for all Indian health care providers to utilize.

This system is essential so as to record health data, justification for budget requests, and documentation of the level of need for IHS.

New language is proposed authorizing the IHS to enter into contracts, agreements or joint ventures with other federal agencies. It is our recommendation that tribal governments be included in this authorization, which would enhance the government-to-government relationship.

Furthermore, we must recognize that this will be a costly endeavor. Funding should not be diverted from our all to meager attempts at patient care. This item should be funded in the context of an appropriations bill that makes progress to close the gap created by unmet needs.

Conclusion

When the people living in the 14 counties of the Cherokee Nation turn on the news, they hear that the federal government has more than a trillion dollars in surplus and is spending billions on a missile defense system that doesn't work, and billions to provide health care for people living in other countries. We wonder why the good people in our Congress have forgotten their commitment to provide health services to American Indian and Alaska Native people. Could we just exchange one anti-ballistic missile for funding to alleviate the illness, pain and suffering in Indian Country? The reauthorization of the Indian Health Care Improvement Act is an important step forward. But it can only make a positive impact on the health of AI/AN if it is accompanied by an appropriations bill that provides funding to carry out the goals of the Act.

It has been said, "great nations, like great men, keep their promises." As I see it, S. 2526 simply allows Congress to fulfill the promises it has made to tribal leaders. The health of Indian people continues to lag that of other Americans. The members of this Committee are well aware that the health program is woefully underfunded. The total unmet need is $1.2 billion. This amount is needed to eliminate the *current* health deficiencies in Indian country. Indian tribes throughout the country, the National Congress of American Indians, the National Indian Health Board, and regional tribal organizations all strongly support this bill. The Cherokee Nation therefore urges the Committee to enable Congress to fulfill the promises it made to the Indian people in P.L 93-638.

After all, Cherokee families, our children and our elders are the ones who need health care. The Cherokee Nation takes great pride in delivering health services in our area just as well as, if not much better, than any federal agency or private provider ever could. This bill will enable us to make our health system more efficient and more responsive to the needs of our tribal members.

The Cherokee Nation looks forward to the day when it can come to this Committee with nothing but positive reports about the elevation of the health status of American Indians and about a true partnership between the IHS, Indian tribes, and urban Indian organizations.

S. 2526 furthers and strengthens Congress' historic self-determination, self-governance and tribal policies. It should become law.

Thank you Mr. Chairman and Members of the Committee, for the opportunity to testify in strong support of this important legislation.

THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

Testimony of

Barbara Namias, President
National Council of Urban Indian Health

Before the
Senate Committee on Indian Affairs

On
The Indian Health Care Improvement Act
Reauthorization of 2000, S.2526

July 26, 2000

THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

"Between the intentions of the lawmakers and the reality of regulatory actions lies the *service gap* that confronts the urban Indian. The result is untold desperation and waste of human resources."

Final Report of the American Indian Policy Review Commission, Vol. 1, p. 436 (emphasis added).

I. INTRODUCTION

Honorable Chairman and Committee Members, my name is Barbara Namias, President of the National Council of Urban Indian Health (NCUIH). I am a member of the St. Regis Mohawk Tribe, and also the Health Director of the North American Indian Center of Boston. On behalf of NCUIH, and its 31 member programs, I would like to express our appreciation for this opportunity to testify before your Committee on the reauthorization of the Indian Health Care Improvement Act (IHCIA).

Founded in 1998, NCUIH is the only national membership organization of urban Indian health programs. NCUIH seeks, through education, training and advocacy, to meet the unique health care needs of the urban Indian population. Title V urban Indian health programs provide a wide range of health care and referral services in 34 cities, actively serving approximately 150,000 urban Indians per year.[1] NCUIH is the successor organization to the American Indian Health Care Association which provided advocacy and educational services on behalf of urban Indian health organizations for nearly 15 years prior to the establishment of NCUIH.

NCUIH'S Prior Testimony. On March 8, 2000, the former president of NCUIH, Kay Culbertson, presented detailed testimony on the technical aspects of the IHCIA. I will not repeat that detailed analysis here, except on the two issues left unresolved therein: the definition of "urban Indian" and the status of the Oklahoma City Clinic and the Tulsa Clinic.

In general, my testimony will focus on the unique circumstances of urban Indians, the Federal obligation to address urban Indian health care needs, and the ongoing need of urban Indians for health services.

---

[1] According to the 1990 census, 62.3% of American Indians and Alaska Natives reside off reservation. At that time, that figure represented 1.39 million of the 2.24 million American Indians and Alaska Natives. The updated 1990 census identified 58% of American Indians and Alaska Natives as living in urban areas (the other off-reservation Indians live in rural areas). This percentage has probably increased significantly since 1990. See also attachments A and B (demographic charts).

II. NCUIH STRONGLY SUPPORTS THE NATIONAL STEERING COMMITTEE'S RECOMMENDATION BUT WITH CERTAIN REFINEMENTS ON MATTERS THAT RELATE TO URBAN INDIANS

NCUIH strongly supports the recommendations of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act which form the basis of S. 2526, although we are asking for a few important refinements.

NCUIH, on behalf of the urban Indian health care organizations, was an active participant in the activities of the National Steering Committee in developing the recommendations. This initiative brought together the Indian Health Service, Indian Tribes, and urban Indians in a united effort to develop sensible and effective amendments to the IHCIA, as well as certain other Federal laws which affect the provision of health care services to Indian populations (such as the entitlement programs Medicaid and Medicare, as well as the Federal Tort Claims Act). While some of the discussions were spirited, the parties worked together with the goal of speaking with one voice, achieving an extraordinary level of consensus.

NCUIH has several suggestions for refinements to S. 2526. NCUIH has been in discussion with other members of the National Steering Committee about achieving a consensus position on these suggestions and believes that such a consensus will be achieved. The first two suggestions are critical to the status and identity of urban Indians in Federal Indian health care policy; the second two are principally important for purposes of clarity. In the proposed amendments, new language is underlined; deleted language is struck out.

A. Critical Amendments Regarding the Status and Identity of Urban Indians in Federal Indian Health Care Policy. These first two amendments go directly to the core provision of health care support by the Federal government to urban Indians.

(1) First Suggested Amendment: The existing Indian Health Care Improvement Act includes urban Indians in the Congressional policy statement:

> "it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to 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:"

25 U.S.C. Section 1602(a)-(b) (emphasis added). S. 2526 does <u>not</u> include a reference to urban Indians in the equivalent paragraphs. Removing "urban Indians" from this important policy statement would imply that the Congress no longer considers the health status of urban Indians to be a national priority. We have been informed that this was an oversight and therefore recommend the restoration of the language as follows:

"SECTION 3. DECLARATION OF HEALTH OBJECTIVES

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

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

(2) to raise the health status of Indians and urban Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto;"

(2) Second Suggested Amendment. In the existing Indian Health Care Improvement Act, the definition of "Indian" includes members of federally recognized tribes and, for certain purposes, members of terminated tribes, state recognized tribes, tribes that may now or in the future be recognized, and Alaskan Natives, among others. The definition of "Urban Indian" includes members of all of these groups (including members of Federally recognized tribes) who reside in an urban center.

In S.2526, the definition of "urban Indian" was changed from that provided for under current law in a manner which would eliminate some Indians currently eligible for services at urban Indian programs. This has been explained as an unintended omission and there has been general consensus on the National Steering Committee to restore the original language. Set forth below is the consensus change for restoring the current law definition of "Urban Indian" to S. 2526:[2]

"SECTION 4. DEFINITIONS.

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

"(A) regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those 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;

"(B) is an Eskimo or Aleut or other Alaskan Native;

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

[2] This change restores the meaning but not the structure of the definition of "Indian" and "Urban Indian." Under current law, "Urban Indian" refers to certain exceptions found within the definition of "Indian;" now the definition of "Urban Indian" is being set out in full separately and the definition of "Indian" has been shortened as described in Section II.B.1, below.

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

It is important, in taking into account the unique historical circumstances of urban Indians, to retain the definition found in current law. As discussed in Section IV. H below, the urban Indian community consists of Indians from a wide variety of backgrounds, almost all of whom can tie their urban existence to some Federal policy or action. Many of these Indians are in urban areas due to some traumatic disruption in their connection with their Tribes, or because something has happened to their Tribes (termination or marginalization such that they are not currently federal recognized). As a result, unlike the Indian population on reservations, most, but not all are members of federally recognized tribes. Yet they are all Indian; they are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.[3]

B. Clarifying Amendments. The final two proposed amendments are intended principally to ensure clarity when it comes to defining critical terms; no actual change in the meaning of the terms discussed here is intended by NCUIH.

(1) First Suggested Amendment. The definition of "Indian" has been substantially revised in S. 2526 from current law, principally by separating out sub-definitions which chiefly apply to urban Indians. NCUIH accepts the new structure of the definition, but has a

---

[3] The Executive Director of the Seattle Indian Health Board, Ralph Forquera, M.P.H., commented eloquently on this issue in a May 24, 2000 letter to NCUIH:

> "There are two principle reasons why I believe that the definition should remain as is. First, the Act itself continues to address the health needs of all Indian people, not just those living on or near reservations. The redesign of the Indian Health Service in 1996 and adoption of the I/T/U model further supports this claim. Clearly the Congress intended for there to be a separation between 437 and 638. Thus, the adoption of the 638 language now, in my opinion, would tarnish the original Congressional intent by shifting the Act to a tribally based orientation.
>
> "Second, the conditions that lead to the original enactment of both the Act itself and Title V in particular have not changed. There remains a large and growing group of Indian people who are handicapped by poverty, inadequate education, and other socio-economic challenges that contribute to diminished health status. Many continue to be victimized by alcoholism, violence, and the myriad temptation that diminish one's capacity to achieve optimal health. The social dynamics that served to disenfranchise Indians throughout the century remain. Indians, particularly in cities, continue to struggle with identity and acceptance both within Indian Country and within the nation as a whole.
>
> "But perhaps the most compelling reason to continue the broader definition of Indian is the psychic benefits. The ability of urban programs to provide the gift of acceptance to those Indians who by circumstances or policy were denied their rightful identity as an Indian person is vital, in my opinion, to improving the health status of this group. Only in the past few years have I personally begun to appreciate the tremendous emotional burden many Indian people have had to bare by being denied their identity through structural limitations. Not knowing who you are is one thing; but knowing and not feeling accepted by your peers has devastated many Indian people. I have had the good fortune to witness the positive effect that acceptance can play in the lives of several here in Seattle. The health effect of this simple practice is enormous."

recommendation regarding the definition of "Indian." The definition used in S. 2526 is a cross-reference to the definition for "Indian" from the Indian Self-Determination and Education Assistance Act. NCUIH supports using the ISDEAA definition, but believes that it makes more sense, as a matter of clarity and good drafting, to spell-out the actual definition of a term than to have this legislation (S. 2526) define the term by referring to another act (Indian Self-Determination and Education Assistance Act) which the reader may or may not have readily available, or otherwise may have difficulty obtaining. Also, by using the actual definition of "Indian," as NCUIH proposes, any concern that a reference to the Indian Self-Determination and Education Assistance Act is intended, in some way, to incorporate some aspect of its policies and purposes into the wholly separate Indian Health Care Improvement Act, is eliminated. NCUIH's recommended language is set forth below:

"SECTION 4. DEFINITIONS.

"(10) INDIAN—The term "Indian" means a person who is a member of an Indian tribe ~~and "Indians" shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.~~"

(2) Second Suggested Amendment. The definition of "Indian tribe" has been changed in S. 2526 from current law, principally by removing a spelled-out definition of "Indian tribe" and replacing it with a cross-reference to the definition for "Indian tribe" from the Indian Self-Determination and Education Assistance Act. NCUIH supports using the ISDEAA definition, but believes that it makes more sense, as a matter of clarity and good drafting, to spell-out the actual definition of a term than to have this legislation (S. 2526) define the term by referring to another act (Indian Self-Determination and Education Assistance Act) which the reader may or may not have readily available, or otherwise may have difficulty obtaining. Also, by using the actual definition of "Indian tribe" as NCUIH proposes, any concern that a reference to the Indian Self-Determination and Education Assistance Act is intended, in some way, to incorporate some aspect of its policies and purposes into the wholly separate Indian Health Care Improvement Act, is eliminated. NCUIH's recommended language is set forth below:

"SECTION 4. DEFINITIONS.

"(12) INDIAN TRIBE – The term "Indian tribe" means any Indian tribe, band, nation or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians ~~shall have the meaning given such term in section 4(e) of the Indian Self-Determination and Education Assistance Act.~~"

C. Oklahoma City Clinic and Tulsa Clinic. Section 512 of S. 2526 is concerned with the status of the Oklahoma City Clinic and the Tulsa Clinic. S. 2526 would make the Tulsa Clinic a permanent program. NCUIH's supports making both the Tulsa Clinic and the Oklahoma City Clinic permanent programs.

D. Negotiated Rulemaking. NCUIH would like to note the negotiated rulemaking provisions in the S. 2526 and emphasize how important it is that there be urban Indian representation, as the bill provides, in those negotiations.

III. GUIDING PRINCIPLES FOR URBAN INDIAN HEALTH PROGRAMS

In 1994, urban Indian health providers, during the tenure of the American Indian Health Care Association - NCUIH's predecessor organization - met in San Diego and adopted four "Guiding Principles." These principles still hold true for NCUIH's current efforts on behalf of urban Indians and directly address the relationships between and among urban Indians, Indian Tribes and the Federal government.

A. Sovereignty of the Tribes. The first principle addresses the understanding of urban Indians regarding the central importance of tribal sovereignty and the government-to-government relationship between Tribes and the United States:

> **Sovereignty of the Tribes:** ***We believe that tribal sovereignty, based on government-to-government treaties and trust responsibilities, along with certain moral obligations, of the United States government, is the foundation for all Indian affairs, including health care.***

In the Steering Committee's deliberations, there was recognition of the importance of emphasizing the sovereignty of tribal governments and the Federal government's trust obligation to Tribes and tribal peoples. There was also a recognition of the historical circumstances, largely a result of Federal government actions and policies, which gave rise to urban Indian communities consisting of Indians from a wide variety of tribal backgrounds (these circumstances are discussed in Section IV).

Although Congress has been specific about its commitment to both Tribes and urban Indians,[4] we recognize that, despite our common interest in health services, Tribes and urban Indians generally occupy different places in Federal Indian policy. Federally recognized tribes have sovereignty and a trust relationship with the United States; as a result there are many different federal laws addressing that relationship in such areas as land, water, criminal justice, and jurisdiction, which have no applicability to urban Indians. Although most urban Indians belong to federally recognized tribes, urban Indians do not aspire as such to be recognized as having sovereign powers or as being in a government-to-government relationship with the United States.

B. All Indian People. The second principle addresses the reality of the urban Indian experience.

---

[4] Congress has made clear, as set forth in the current Indian Health Care Improvement Act, "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. Section 1602(a).

All Indian People. ***We believe that all Indian people, regardless of tribal affiliation, blood quantum, or their place of residence are entitled to all the necessary health resources and services to achieve the highest possible health status.***

Many Indians, from many different tribes have ended up in urban areas. As described in greater detail in Section IV below, for a variety of reasons, mostly traceable to federal government action, they find themselves among the ranks of the urban poor. Most are members of Federally recognized tribes; some are not. Many among the latter have become so disconnected from their tribes that it is difficult for them to obtain tribal membership, or their tribes have been terminated or otherwise marginalized. Yet they are all Indian; they are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.

C. Traditional Medicine. For urban Indians, as much as for reservation Indians, traditional medicine is critically important to maintaining a connection with tribal and cultural identity and plays an important role in a holistic approach to their health.

Traditional Medicine. ***We believe that traditional Indian medicine is intrinsic to our culture and essential to a holistic approach to healing the body, mind, and spirit of our people.***

Urban Indians stand shoulder-to-shoulder with their reservation brothers and sisters on the critical importance of preserving and integrating traditional medicine into Indian health programs.

D. Unified Urban/Tribal Partnership. We believe in working closely with the Tribes.

Unified Urban/Tribal Partnership. ***We believe that a unified Indian partnership is vital to assure access to comprehensive health services to achieve the highest possible health status for all Indian people.***

Many tribal peoples live in urban areas; some permanently, some periodically.[5] However, in many urban centers, it is not practical for any one tribal government to set up an outreach to only its own tribal members. In fact, "in some urban centers, there are as many as 40 tribal governments nearby, and representation of tribes on urban Indian programs might include over 80 different tribes."[6] The urban Indians have developed skills necessary for survival (if not

[5] One Federal court has noted that the "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." United States v. Raszkiewicz, 169 F.3d 459, 465 (7th Cir. 1999)

[6] U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986), p. 38.

yet prosperity) in the urban environment;[7] the tribes are the great repository of cultural tradition and knowledge. The practical approach is the current approach: working together, Tribes and urban Indian health organizations can provide the best possible health care for our people. The extraordinary level of cooperation in the work of the National Steering Committee is proof positive of the value of this approach.

IV. FEDERAL POLICIES AND THE URBAN INDIAN

> **"Most Indians who migrate to the cities say they would have preferred not to do so at all."**
>
> Final Report of the American Indian Policy Review Commission, Vol. 1., p. 436.[8]

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. The result of this "course of dealing," however, is the same: a Federal obligation to urban Indians.[9]

A. The Federal Relocation of Indians. The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the distress by finding jobs for Navajos who wanted to work off the reservation. Little or no job opportunities existed on the reservation, so an employment campaign was developed for off-reservation employment. Shortly afterward, the

---

[7] "The Committee views the health dilemma of urban Indians as a serious obstacle in their quest to become self-sufficient and participating citizens. Fortunately, an evolving Congressional policy addressed to this problem has served to provide the essential experience and information for the provisions contained in Title V. That evolving policy has been built on the concept of self-determination with the Indians themselves managing federally subsidized health efforts tailored to fit the health circumstances of Indian populations residing in specific urban centers." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) p. 2652 and 2752.

[8] For a more detailed summary of the history of off-reservation Indians see Attachment C, which is the relevant chapter from the Final Report of the American Indian Policy Review Commission.

[9] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added). Congress acknowledged this in its findings to the Native American Housing Assistance and Self-Determination Act: "The Congress through treaties, statutes *and the general course of dealing* with Indian tribes, has assumed a trust responsibility . . . for working with tribes *and their members* to improve their housing conditions and good economic status so that they are able to take greater responsibility for their own economic condition." 25 U.S.C. 4101(4). Notably, NAHASDA also applies to state-recognized tribes. 25 U.S.C. 4103(12)(A).

BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes.

The BIA employees who developed the program made many mistakes and miscalculations. Even before the 1950's had ended there was concern that many relocatees were experiencing great difficulty adjusting to life in a large city, or to their jobs. Some felt they were being stranded far away from home. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans oversee to find work – something the Federal government would never have done. Many understood the relocation program as just another form of "termination." A Jesuit priest on the Fort Belknap Reservation noted that relocation programs drained the reservation of much of its potential leadership, further weakening tribal governments.

All told, between 1953-1961, over 160,000 Indians were relocated to cities.[10] Where they quickly joined the ranks of the urban poor.[11] Set forth below is a description of the experience of Indians who relocated.

URBAN GENOCIDE - THE INDIAN IN THE CITY (excerpts)[12]

"The economic status of the reservation Indian is far below the poverty bracket. This is due to the lack of employment both on and off the reservations with the exception maybe of the larger cities. The main source of employment to be found on most reservations is working with the Bureau of Indian Affairs. In this way, the "Bureau" can instill its white culture on the Indians and eventually brainwash them into working against their own people. The reservation towns bordering the reservations can offer no employment for Indian people because of the great amount of racism, discrimination and prejudice that exist among the whites and other non-Indians.

"Consequently, the bad conditions and individual economic situations that have evolved from these indignities have forced the Indians to seek other sources of employment and education. With 75 percent of the Indian population unemployed for three generations, parents of Indian children could not, and still cannot afford to send them to public schools and have to depend on the government to educate them in "free" government boarding schools. Since it was a law to send their children to school, small children were forced to leave their parents and be shipped off to school thousands of miles away from their homes. These Indian boarding schools, established in various areas, were the prime weapons used to inculcate the white culture among the children or, in the common terms used at that time, "to civilize the barbarians." Any part of

---

[10] 1992 Roundtable Conference, Urban Indian Health Programs, Indian Health Service, "Working in Unity Toward our Future." p.2.

[11] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

[12] This document was obtained from the National Urban Indian Policy Coalition. The author of this piece is unknown.

the Indian culture was forbidden and the children were physically beaten if they used their native tongue or practiced their own dances. It has not been until just recently that this law has been officially lifted and is not in force, but the principle motive of de-Indianizing the Indians is still in effect.

"During the summer months while school is not in session, they send these Indian students to white homes to work as indentured servants. After graduation, they are sent directly out on relocation from the schools into the cities.

"Conveniently enough, the relocation program has been established to speed assimilation of Indians into the cities at this time of dead-end streets, reservation confusion and unemployment. Through this program they relocate the younger Indians from the ages of 18 to 36 on direct employment or vocational training. It is a one-way ticket to the city in hopes that you will melt with the melting pot and forget you are Indian or still have a reservation that the white man does not have yet.

"Numerous problems have developed as the result of the "dislocation program," therefore the following chapters will focus on the urban Indian situation.

What Happens to the Indians After Arrival in the Cities

"On arrival to the city on relocation, the individual Indian has in his possession an envelope with orders and instructions, telling where to go and what to do. First of all, he is to report to the Bureau of Indian Affairs if he arrives during office hours. If not, he reports to a BIA-approved hotel until the next day if he has any money.

"If they have time to see you the first day, they dole out a small amount of money to last until the end of the month if he is on the training program or until the next week if he is seeking employment. If they do not have time to see him the first day, he is to come back the following day at office hours and maybe some one will see him. In the meantime, he can sleep in the park or walk the lone deserted streets all night long.

"When he is received at the BIA headquarters in the city, he attends a short orientation period and an elderly lady will counsel him about sex and how to dial "0" for the operator on the telephone. A brief question and answer period follows and he is told to come back the next day at eight AM or to report to his designated school.

"The BIA locates his place of residence in the city and he is required to stay there if he is a student. They will discontinue his subsistence if he opposes and he will not be eligible for any more aid.

"The vocational school he is sent to may not be the particular training he originally signed up for back on the reservation, but this is the school he is required to attend.

"If the relocatee signed up for direct employment, he must take the first job available even if it is not his trade or type of work he wants. He is told it will be temporary until the type

of job he wants comes up but after he receives his first salary on his temporary janitor job, he is cut off their records and cannot receive any additional help after he quits, gets fired or the job runs out.

"The "Bureau" pays the student's tuition in the vocational school directly to the school. The student receives subsistence twice a month, doled out in payments of $74.00. From this amount, he must budget $59.00 per month per rent, and the other $15.00 must be divided into his expenses for food, cab fare, medical care, clothes and whatever else that should develop during the month. This budget was made up in 1953 when the program first developed and has not taken into consideration the rises in living and the area or city he is in. California has the highest cost of living especially in San Francisco, which is the central concentration point of relocatees coming from every reservation in existence today. This income is far below the poverty bracket nation-wide, yet this is the "help" the Indian Bureau is giving.

"All persons on the relocation program are issued a medical card which they can present to a physician and receive medical help up to a six-month period. The only problem here is that these medical cards only guarantee to pay $4.00 of the entire bill when the office calls alone are $5.00 at the very minimum.

What Problems They Face and Why

"The cultural background of the American Indians differs extremely from the white culture, creating a problem of communication between the two. Not only this, but the Indian culture has also been corrupted, bringing about a drastic change of social environment. This disintegration of culture has been attributed to disturbing early experiences in school, the generally poor level of education, poverty and the ambivalent position of the government in relation to the Indian.

"Prejudice and discrimination which does exist near reservations or anyplace where there is a large concentration of Indians, (although now in the city and away from being singled out as being an Indian), tends to have developed hostile and stereo-typed attitudes towards the other groups of society. The Indians have also collectively experienced a deterioration of personality, self-doubt, self-hate, impulsive and suspicious behavior, feelings of inferiority, deviant behavior, mental illness and suicidal tendencies.

"Depending on the environmental background, these adverse behaviors vary. Individual exceptions are due to the degree of orientation to the white culture or restored self-image through education.

"In dealing with the many Indian people who go through the BIA agencies, or any other type of agency established in the cities for employment or vocational training, the employees lack the experience of knowing the type of environment the individual Indian has been subject to and they do not know how to handle his particular situation. In many cases even where minority people hold agency positions, generally, they have developed superiority attitudes over the people they are trying to help and therefore stunt their full capabilities for helping others.

"[Many businesses] resent the BIA in its assistance of seeking employment for the Indian relocatees. This is due to the business' general dislike of any form of government transactions or to be told how to run their business concerns. This creates a great amount of conflict and the BIA, in order to retain a certain amount of prestige, often finds the Indian relocatee employment with a business concern that pays a low wage scale, hard labor with no company obligations, such as insurance policies, sick leave and vacation with pay. These small businesses often take no safety precautions and are constantly hood-winking the safety inspectors. Consequently, the Indian relocatees are more or less siding with the illegal aspects of the concern in which they are employed in order to retain their jobs. Employment competition is great and the relocatees can be dismissed from their job for little or no cause at all, and they are often plagued by this fear of being fired.

"In the event that a relocatee is fired for one reason or another and needs assistance, he cannot go back to the BIA for further help. The BIA tells him that his files have been sent back to his agency and they have no more funds or time to help him because their hands are tied with the other relocatees who are coming in.

"The budget set up for financing a student in vocational training are not only inadequate for one person's needs, but are not set to the area standards of living. In other words, they are transformed from one pocket of poverty to another, which in this case would be from a reservation to an urban ghetto.

"The vocational schools that Indian relocatees are sent to, in most cases are not accredited and after graduation from one of these schools, the relocatee cannot obtain a job. Most of the teachers in vocational schools are not qualified teachers, and there is a great shortage of instruction. The BIA gives the schools extra money for materials yet the conditions and facilities in these schools are still very bad. The students come out of these schools unqualified and inexperienced in the type of work for which they thought they had been trained and cannot find suitable employment.

"There are more and more students who are sick and tired of being treated as second-class people who do want to get a decent education and go to junior colleges and universities. The biggest problem here is not being able to get any finances, "Bureau" or otherwise. Also, Indian students' second-rate educations do not prepare them well enough for college work. Most reservation Indians are subject to irregular school and employment backgrounds and a great majority of the younger Indians have criminal or prison records. This does not mean that they cannot do the work academically; but, basically, they have never had the full opportunity to do so.

"The Bureau of Indian Affairs sends newly-arrived relocatees to unsanitary, immoral, crowded and unsafe places of residence. If the student wants to leave these conditions, the landlord promptly calls the BIA about the matter and the student is required to live there or have his subsistence discontinued. In one of the girls' boarding homes the landlady encouraged parties and drinking and let the girls' boyfriends come over. Then she would go into their rooms and take pictures of the different couples sleeping together. If the girls wanted to leave, she would then threaten to blackmail them with the pictures she had and in this way would keep her

business. A business college for female relocatees also housed the students, putting four girls to one small room and charging $100 per person, not including food or utilities. This establishment also received additional money from the BIA for recreational purposes which the girls never did see. If the girls tried to leave their residence, they were threatened with expulsion from the business college and have their subsistence discontinued. Most of these young Indian girls were between the ages of 18 to 20 years, who were eventually expelled for little or no reason and left to roam the city streets. Individual follow-up showed that 80 percent of these girls got pregnant, were drinking excessively and were living with men from time to time. This college is still in operation receiving relocatees from the Bureau of Indian Affairs.

"A boys' boarding house in the city was over-crowded with four bunks to a room, no studying facilities, unsanitary conditions, inadequate food and displaying a sign in the front of the house, CONDEMNED.

"These are typical living conditions, Indian youth are subject to when placed in the city through relocation. When a young Indian approached a BIA counselor why they had to live under such adverse conditions and was told, "The filthiest conditions you Indians are put under, the more at home you will be."

"Landlords and vocational schools are getting wise to the BIA and are making the largest profit and racket out of the Indian business at the cost of young Indian lives.

"Indian health is generally poor due to the economic standards and lack of proper diet and nutrition. Free medical facilities are provided on all reservations due to the unsatisfactory health conditions. Tuberculosis, cirrhosis of the liver, sugar diabetes, and trichoma are a few of the more prevalent diseases which Indian people are susceptible to. Trichoma, which is an eye disease, is very rarely heard of among Indians. Poverty conditions breed diseases.

"The BIA believes that when an Indian leaves the reservation, he suddenly leaves his "Indianness" and becomes a healthy, happy human being, and needs no more of the medical services he had before. Consequently, Indian health in the city becomes twice as bad as it might have been before because he cannot afford good medical care.

"Pregnant Indian women risk possibly losing their child by having to return to the reservation their last month so that they can receive medical care upon delivery of their baby.

"From the time Indians were victims of wars, they lost their identity which comes from pride and self-esteem. Indians became a lost people exhibiting schizoid behavior at times. An Indian who does not like himself, does not like other Indians because he can see himself reflected in the others. An Indian suffers from inferiority plus self-hate that leads to trying to escape these unbearable conditions. By escaping, he is rejecting the society that has made him this way. His means of escape is either through alcohol or suicide which are 100 percent times higher than the national average among the American Indians.

"An internal problem of self-identity and lost culture plus an external problem of discrimination and racism by people in power has suppressed and made what is left of the American Indian today."

Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities. They maintain their Indian identity even if, in some cases, these "descendants have been unable to re-establish ties (including membership) with their tribes."[13]

B. Failure of Federal Efforts to Economically Develop the Reservations. The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA relocatees and quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."[14]

C. Termination of Tribes. In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties.[15] The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

---

[13] See Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 22-23.

[14] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[15] Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 23.

D. Indian Patriotism – World War I and World War II. Many Indians served the United States in time of war[16] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

E. The General Allotment Act. The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. CITE. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. For the purposes of this testimony, we only need to note that some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

F. Non-Indian Adoption of Indian Children. The common practice of adopting Indian children into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.[17]

G. Boarding Schools. The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

H. The Fracturing of the Indian Nations. The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, state recognized tribes, and unrecognized Tribes (that is, unrecognized by the Federal government);[18] and adoptees.

---

[16] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

[17] In recognition of the severity of this problem, Congress passed in 1978 the Indian Child Welfare Act to give Tribes and Indian parents a greater say in the adoption process for Indian children. See Indian Child Welfare Act of 1978, 25 U.S.C. Sections 1901-1963.

[18] There are still scores of tribes working their way through the byzantine and labyrinthine acknowledgement process, which is widely criticized for its glacial pace and alleged bias against certain Indian groups. Some tribes, like the Lumbee Tribe of North Carolina, have been declared ineligible to go through the administrative process and,

V. THE FEDERAL GOVERNMENT AND THE PROVISION OF HEALTH CARE TO URBAN INDIANS

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off the reservation.

> "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there.*"

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).[19] Congress has "a responsibility to assist" urban Indians in achieving "a life of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

The Supreme Court has also acknowledged the duty of the Federal government to Indians, no matter where located: "The overriding duty of our Federal Government to deal fairly

---

therefore, are awaiting Congressional action on their long-prepared, extensively documented petition for federal recognition.

[19] "The American Indian has demonstrated all too clearly, despite his recent movement to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

"The Committee is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of H.R. 2525. Building on the experience of previous Congressionally-approved urban Indian health prospects and the new provisions of title V, urban Indians should be able to begin exercising maximum self-determination and local control in establishing their own health programs."

Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at p. 2754.

with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber*, 318 U.S. 705 (1943). In other areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987).[20]

Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

> "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy"

25 U.S.C. Section 1602(a)(emphasis added). In so doing, Congress has articulated a policy encompassing a broad spectrum of "American Indian people." Similarly, in the Snyder Act, which for many years was the principal legislation authorizing health care services for American Indians, Congress broadly stated its commitment by providing that funds shall be expended " for the benefit, care and assistance of the Indians *throughout* the United States for the following purposes: . . . For relief of distress and conservation of health." 25 U.S.C. Section 13 (emphasis added).

The courts have also stated that there is a trust responsibility for individual Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members living collectively or individually, on or off the reservation*." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually*, as well as collectively, *and off the reservation*, as well as on it." *St. Paul Intertribal Housing Board v. Reynolds*, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. *The increasing urbanization of American Indians has created new problems for Indian tribes and*

[20] Federal responsibility for Indian health care is frequently declared "primary" but it is not exclusive and preemptive of state responsibility. See *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987). Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cond Cong. & Admin. News (USCAN) 2652, 2657.

> *tribal members.* One of the most acute is the need for adequate urban housing. Both Congress and Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. *This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine . . . .*"
>
> Id. At 1414-1415 (emphasis added).

This Federal government's responsibility to urban Indians is rooted in basic principles of Federal Indian law. The United States has entered into hundreds of treaties with tribes from 1787 to 1871. In almost all of these treaties, the Indians gave up land in exchange for promises. These promises included a guarantee that the United States would create a permanent reservation for Indian tribes and would protect the safety and well-being of tribal members. The Supreme Court has held that such promises created a trust relationship between the United States and Indians resembling that of a ward to a guardian. See *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). As a result, the Federal government owes a duty of loyalty to Indians. In interpreting treaties and statutes, the U.S. Supreme Court has established "canons of construction" that provide that: (1) ambiguities must be resolved in favor of the Indians; (2) Indian treaties and statutes must be interpreted as the Indians would have understood them; and (3) Indian treaties and statutes must be construed liberally in favor of the Indians. See *Felix S. Cohen's Handbook of Federal Indian Law*, (1982 ed.) p. 221-225. Congress, in applying its plenary (full and complete) power over Indian affairs, consistent with the trust responsibility and as interpreted pursuant to the canons of construction, has enacted legislation addressing the needs of off-reservation Indians.

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See *Joint Tribal Council of Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA,[21] but also in NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

VI. BARRIERS TO MAINSTREAM HEALTH CARE EXPERIENCED BY URBAN INDIANS[22]

> **"The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for**

[21] As originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, *A Political History of the Indian Health Service*, Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

[22] This section is based on the September 30, 1989 report prepared for the American Indian Health Care Association, by Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst. The framework for the report is the 1988 report Minority Health in Michigan: Closing the Gap.

> **subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the *service gap* reveals itself again."**
>
> Final Report of the American Indian Policy Review Commission, p. 437 (emphasis added).

The status of Urban Indian health is as poor as that for reservation Indians.[23] This section describes the many barriers that are still faced by Urban Indians in their efforts to access adequate health care in the urban environment:

Physical/geographic barriers can include (1) telephone availability; less access to transportation; and (3) high mobility. Many Native Americans do not have phones, increasing the difficulty in making appointments. For example, in Arizona, thirty percent of urban Indians have no household access to phone services. Indian people have much less access to private vehicles than the general population. Not having a vehicle creates barriers for people who must make arrangements with others to bring them to appointments. Public transportation (if available) makes for a longer travel time and can be costly. The high mobility of Indian people is another barrier to care. People who move often are not able to follow with the same provider, and this disrupts continuity of care and can lead to a decrease in the quality of care. When a person moves to another area, they must go through the system again to qualify for benefits, locate a provider, and receive care. In addition, movement back and forth between the reservation is common, which can significantly affect the ability of health professionals to provide prompt, quality follow-up care.

Financial/Economic barriers also contribute to the poor quality of urban Indian health care. People who do not have the resources, either through insurance or out-of-pocket, to pay for prevention and early intervention care may delay seeking treatment until a disease or condition has advanced to the stage where treatment is more costly and the probability of survival or correction is lower.

Medicaid is available for urban Indians, but difficult to access. Applying for Medicaid or other medical assistance is a long and detailed process, presenting many barriers to people who don't understand the system or lack the necessary skills to complete the paperwork involved. Furthermore, the required documentation is difficult for many urban Indians to obtain. For example, if one does not have a car, one may not have a drivers license. With high mobility among urban Indians, there is likely to be no documentation with the current address; or if they have just moved to the city from the reservation, there may be no birth certificate or identification. Once an individual is accepted, access to care is not guaranteed. Because of Medicaid reimbursement rates and restrictions, many providers are reluctant to accept Medicaid patients.

---

[23] See Attachment D for a leading study on Urban Indian health: *Health Status of Urban American Indians and Alaska Natives*, Grossman et. al, Journal of the American Medical Association, Vol. 271, No. 11, p. 845.

Health insurance coverage does not automatically remove financial barriers to care. Many persons, particularly those employed at or near minimum wage, have coverage through plans that do not cover preventive or major medical care. While professional positions generally provide health insurance, service and laborer positions generally do not. Urban Indians hold more of those occupations that do not provide health insurance benefits. Deductibles and co-payments are high enough that many persons who do have health insurance cannot afford to pay them and consequently do not seek care.

No insurance or assistance is another common barrier. Those who have no means to pay for care are often turned away. There is a high rate of urban Indians who are uninsured. For example, in Boston, 87% of the Boston Indian Center's clients have no health insurance, and two out of every three urban Indians in Arizona are uninsured.

Emergency room use is high among the poor, minorities and the uninsured. Unfortunately, emergency room use as a primary medical resource is costly and compromises quality care. Follow-up and preventive services are not possible with emergency room personnel serving as primary care providers. In Arizona, urban Indians use the emergency room 250% more often than the general public.

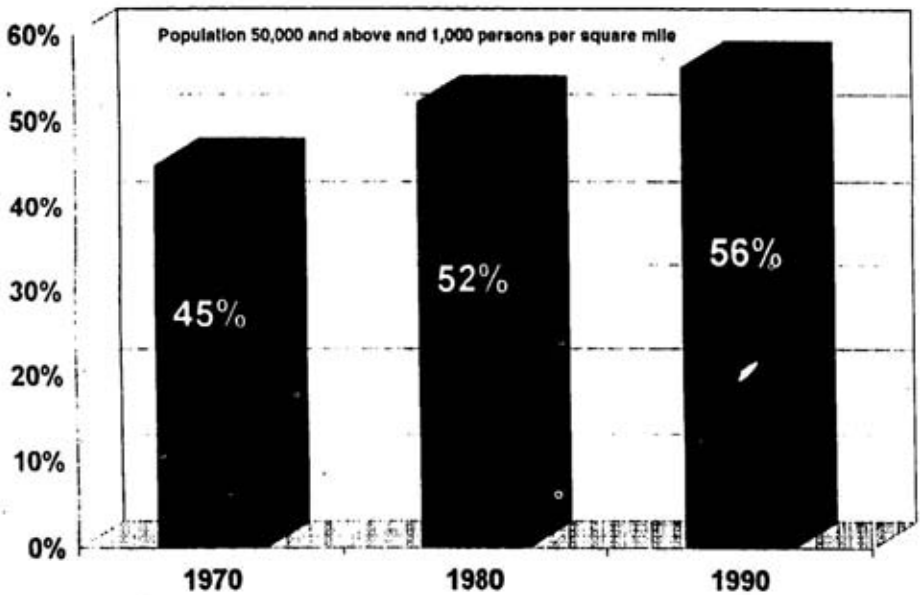
Cultural/structural barriers also exist for urban Indians receiving health care. The Indian Health Service conducted a survey which concluded that the majority of state, county and city health departments do not have the resources to meet the health care needs of urban Indians. Major stumbling blocks are inadequate funds and lack of staff trained to work with American Indians in a culturally sensitive way. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Other factors include a lack of trained Indian health professionals that get placed in urban Indian health programs and inadequate Indian outreach.

X. CONCLUSION

Notwithstanding all the difficulties, urban Indian health organizations, working with limited funds, have made a great difference in addressing the health care service gap for urban Indians. There is much more work to be done. NCUIH thanks the Committee for its support in the past. NCUIH also thanks the Committee for this opportunity to provide testimony on the reauthorization of the Indian Health Care Improvement Act. This legislation will have far-reaching consequences for the health care of American Indians, including urban Indians. NCUIH urges the Committee to support the proposed amendments to IHCIA developed by the National Steering Committee, with NCUIH's proposed refinements. They provide an essential basis for improving the health care of America's native peoples.

Exhibit A

CENSUS 1970, 1980, 1990
U.S. INDIAN POPULATION DISTRIBUTION
INSIDE URBANIZED AREAS



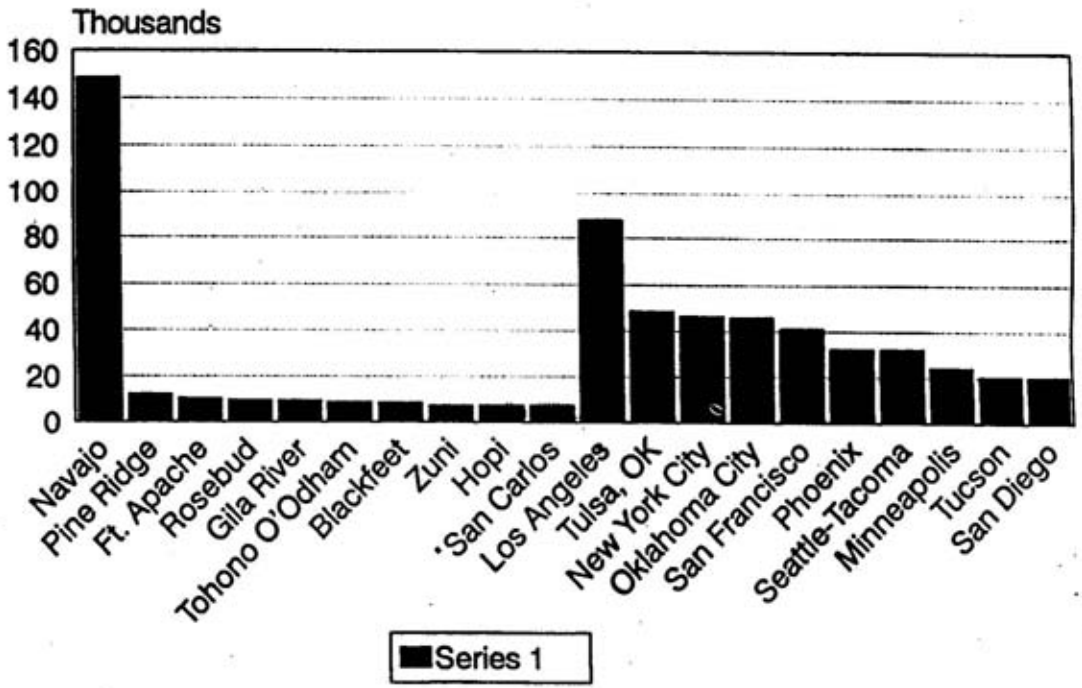
MC: Granis

8/8/94

Exhibit B

10 Largest Indian Reservations

and 10 Largest Urban Indian Population Cities



1990 Census

Exhibit C

[COMMITTEE PRINT]

AMERICAN INDIAN POLICY REVIEW COMMISSION

FINAL REPORT

SUBMITTED TO CONGRESS
MAY 17, 1977

VOLUME ONE OF TWO VOLUMES

Printed for the Use of the
American Indian Policy Review Commission

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1977

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

CHAPTER NINE

OFF-RESERVATION INDIANS

Overview

Almost half of the United States Indian population lives outside the boundaries of Indian reservations. In 1970, 340,000 lived in cities and six cities had Indian populations which are larger than those of any reservation except the Navajo Reservation.[1]

Many of these people moved to cities because of Federal policies. The earliest movements of tribal people away from tribal lands were often the indirect result of policies which diminished the reservation land base to such an extent that Indians had to find homes elsewhere. Educational policies added to the trend by removing Indian children from their homes to off-reservation boarding schools where the children were taught skills which could not be used on reservations. Policies which neglected reservation development, of course, made reservations undesirable places to remain and also affected migration. Some policies, particularly following World War II, were more directly responsible for relocating Indians away from reservations. In addition to robbing reservations of some of their best talent, these policies have resulted in dire circumstances for the large numbers of Indian people who find themselves in urban ghettoes, today.

Despite the fact that the Federal Government must assume some responsibility for the present-day problems of urban Indians, the Government has actually refused to extend those services to urban Indians which they would otherwise receive if they lived on their reservations. Urban Indians do not receive the special Federal programs which are directed to Indians. Strangely enough, they often do not receive the services directed to non-Indians, either. Local, State and county welfare programs often refuse to serve Indians on the grounds that they are the responsibility of the Federal Government.

In this situation, the development of Indian community service centers has been the one optimistic factor. The Federal Government offers these centers little encouragement, however, and they become entangled in bureaucratic and jurisdictional fights.

New policy directions can have a very clear beneficial impact on the desperate urban Indian situation if administrative programs utilize and encourage urban Indian centers.

History[2]

This review of off-reservation Indian history will examine the ways Federal policies have splintered tribes and either forced or encouraged

[1] See A. Levitan and William B. Johnston, Indian Giving (Baltimore, 1975), 5-8.

Indians to move away from reservations in an effort to end the "Indian problem." It will also show how these moves have not solved the problems of poor health, poverty, limited employment opportunities, poor education, and alienation, but have merely transferred them to rural and urban settings.

In the late 19th century, after the Federal Government had succeeded in reducing Indian tribal holdings to small reservations, the policies of neglect, dependency, and assimilation were established. While there were some meager efforts at "reservation development," no significant system of economic and cultural protection was created to permit Indian tribes economic viability and independence. Reservations were often viewed as camps where assimilative tools would be provided prior to the Indian's dispersal among the white population.

Even reservations, however, posed a threat to the Federal Government because they provided a place where Indian people could not be effectively kept from maintaining their identity and culture. So, attempts were made to parcel out tribal lands to Indian individuals in an effort to destroy the communal cohesiveness of tribal society. The continuing assumption on the part of the Federal Government was that assimilation was the Indian's fate. Legislation was based on this assumption.

One of the most obvious examples of Federal action which broke up reservations, strained tribal cohesion, and encouraged subsequent migration of thousands of Indians to other areas was the General Allotment Act of 1887.[3] Indeed, it is not inaccurate to say that the migration of the Indians was a calculated result of this legislation.

The General Allotment Act was, of course, just one example of a long line of Federal legislation and administrative actions which were either designed to or inadvertently resulted in dispossessing Indians of their lands and driving them to seek jobs off the reservation.[4] Oftentimes, the Federal Government was the decisive influence weakening (and sometimes dissolving) [5] the tribal governing structures; it stood by while most of the Indians' choice lands were taken from their control and the resources from the remaining lands were destroyed; it moved Indians off the reservation for job training and employment. More often than not, job training in the cities turned out to be irrelevant, employment opportunities were nonexistent, and furthermore, the Federal Government neglected to provide meaningful assistance in housing, education, or health. As the final insult to those Indians who were victims of this concerted campaign to assimilate them, the Federal Government refused and largely still refuses to recognize its

[1] This historical review is condensed from an extensive history researched and written by Dennis Carroll for Task Force Eight.

[3] 24 Stat. 388.

[4] Also during the 1870's, the Federal Government began the Indian boarding school system which was "designed to separate a child from his reservation and family, strip him of his tribal lore and mores, force the complete abandonment of his native language and prepare him for never again returning to his people." (U.S. Cong. Senate Committee on Labor and Public Welfare, Indian Education: A National Tragedy—A National Challenge, S. Rept. No. 91-501, 91st Cong., 2d sess. 12 (1969).) Some 20 years later, the Indian Commissioner stated that it was the "settled policy of the Government to break up reservations, settle Indians upon their own homesteads, incorporate them into the national life, and deal with them not as nations or tribes or bands, but as individual citizens." Rep. Comm. Ind. Aff., 1890 at VI.

[5] Felix Cohen described the systematical destruction of tribal governing structure and powers of the Five Civilized Tribes. F. Cohen, Handbook of Federal Indian Law, 427-436 (1942 ed.).

responsibility to provide them with the services they would receive on their reservations.

Education through the off-reservation boarding school was another method utilized to alienate Indian people from their culture. This educational model for Indian youth was directed at developing young men and women who could join the mainstream of white, Christian society. Instead, it left a legacy of frustration, depression, and alienation that made Indians unable to pursue the traditions of their fathers, but left them unequipped to participate in white-dominated economy.

The increasing number of Indian people living off-reservation was noticed in two Indian policy studies in the 1920's. The Senate Subcommittee on Indian Affairs' Survey of the Conditions of the Indians of the United States was followed by the well-known Meriam Report.

The Subcommittee conducted and published hearings across the United States, and largely provided the data base for the more concise Meriam Report. The subcommittee's hearings in California were particularly directed at the burgeoning problem of urban Indians. The Government was beginning to notice a new problem area in Indian affairs, but responsive policies would not be instituted within the next half-century. Whatever insights might have been gained from hearing testimony were lost when the Meriam Report published its chapter on "Migrated Indians", and relied on the material presented by Indians' employers rather than the Indians themselves. On this choice of information, the Meriam Report recommended that "no effort be devoted toward building up an independent organization in such cities for migrated Indians, but rather toward establishing cooperative relations with existing agencies which serve the population as a whole."[1]

The Snyder Act of 1921 had given the Commissioner of the Bureau of Indian Affairs broad latitude in spending appropriations for Indian affairs and in developing programs to meet Indians' needs. The legislation simply stated that appropriations were to be used for "Indians throughout the United States." Certainly that clause is broad enough to include those Indians who were forced away from reservations by bad policies, by Federal encouragement, or by economic needs, but the Bureau did not choose to view its role in so expansive a way. The Meriam Report, no doubt, gave scholarly support to this bureaucratic timidness. For many years, the Bureau's failure to serve the increasing urban Indian population went unquestioned.

After World War II, Indian perceptions of reservations and cities began to change. The war showed many Indians a world they had never seen and seldom heard of. There were opportunities for achievement in the military service which they had never found on reservations. They proved themselves capable of using those opportunities and returned home with confident hopes that they could make their reservations better places to live. This hope soon turned to despair as they tackled the obstacles which impeded (and today still impede, see chapter 7) reservation development. Many Indians, however reluctant to leave their communities and families, decided that low quality subsistence was the only future for the reservations and set off for the cities to find work. By 1951, more than 17,000 Navajos

[1] Meriam, Lewis, The Problem of Indian Administration, "The Migrated Indians" ch. XII.

worked away from the reservation, primarily on railroads and agriculture.

At the same time, the Federal policy of assimilation manifested itself in a new way. A theory that reservations were overpopulated gained credence. By 1954, a congressional report entitled, "Survey Report on the BIA" generalized that "most of the reservations are overpopulated, and could not support the population at anything approaching a reasonably adequate standard of living."[7] Rather than pursuing a way to make Indian homelands financially secure places to live, the Federal Government chose to follow a simpler approach: relocation of Indians away from the reservations. Thinning out the population of reservations, however, did not solve the problem. The fact that Indians left the reservation did not mean they were willing to stop being Indians; and whether or not reservations bred some social problems, it could not have been assumed that those problems would be shed at the reservation boundaries. Nevertheless, Federal policy followed exactly that simplistic an approach. Transportation funds were provided, but relocation services were not.

The Federal Government not only failed to provide needed services to the Indians it relocated, but actually refused to provide those services. The Federal relocation program was to be initiated by the BIA but was left to be implemented by local, State and county assistance programs, or churches or humanitarian organizations. The only thing that was shrugged off at reservation boundaries, it turned out, was Federal responsibility.

Indians affected by relocation were not given an opportunity to tell their side of the story until the National Council on Indian Opportunity held hearings in five major cities in 1968 and 1969.[8] The numerous criticisms that were heard at this time fell into three categories: (1) The lack of orientation in relocating from reservations to cities; (2) the low quality of opportunities for work; (3) the confusion of where to turn for necessary services. Federal policy had ignored particular difficulties Indians faced in the cities, difficulties such as language barriers, questions of where to find services or help in emergencies, and the most fundamental problems of daily survival.

The special problems which Indians face when they are away from their reservations are another unique aspect of the Federal-Indian relationship. Whatever historical forces have contributed to these problems, it is apparent that the situation is significant enough to deserve Federal attention.

To solve these problems which the Federal Government largely created and then totally ignored, Indian people themselves have contributed the most recent and the most constructive development in the history of off-reservation Indians. That is the development of urban Indian service centers. Some of these centers have evolved from very small groups organized for recreational purposes into multifaceted operations capable of sustaining programs in educational and vocational training, defense of tenant rights against unscrupulous landlords, psychological and career counseling, various kinds of entertain-

[7] U.S. Congress, House Committee on Interior and Insular Affairs, "Survey Report on the Bureau of Indian Affairs," 1954, p. 25.
[8] National Council on Indian Opportunity, hearings in Los Angeles, Dallas, Minneapolis-St. Paul, San Francisco, and Phoenix, 1968-69.

ment, and the provision of emergency relief. There can be no doubt that today the Indian centers are a sound and creative response to the Indians' frustrations with their urban environment.

The urban Indian service centers have not, however, completely solved the problems urban Indians face. In fact, they have encountered many obstacles which the Federal Government could remove, and have clarified a new policy problem in the administration of Federal programs for urban Indians. There is a unique relationship between the Federal Government and urban Indians, both because of the uniqueness of the problems urban Indians face and because of the uniqueness of the historical factors which made some Indians urban residents. How to administer that unique relationship has not yet been determined. Instead of taking the initiative and providing services to these Indian people, the Government has chosen to argue over responsibility and jurisdiction; these arguments continue to the present day.

Policy and Law Relating to Off-Reservation Indians

The following discussion examines briefly the concept and scope of the Federal trust responsibility to off-reservation Indians.[9] The exclusion of nonreservation Indians from the Federal trust relationship does not follow from a careful legal analysis but rather emanates from perceived practical considerations and the attitude, "it has always been done that way."

While the Federal trust responsibility extends from the Federal Government directly to the tribe, it must be noted the tribe as an entity does not exist without its people. Thus, it can be said that the ultimate beneficiary of the trust is the individual Indian as a member of his tribe.[10]

This is obviously true, for example, when the Federal Government acts to protect an individual Indian's land from being taxed by the State.[11] It is also true, however, when action is taken to protect a tribe's water resources on the reservation.[12] Individual Indians, including most of those living in urban and other nonreservation areas, generally identify themselves in the context of their tribal affiliation.

Probably few, if any, Federal administrators or legislators would disagree with the above comments. Dissent increases, however, when it is suggested that the Federal Government's trust responsibility applies to tribal members living off the reservation as well as to those living on Indian lands. This dissent results partially from the fixed thinking predominant in government that the Indian trust equates with land and nothing more, and partially from the mistaken notion that if an Indian leaves his reservation, it is with a conscious understanding that he is putting his tribe behind and assimilating to non-Indian society. As the historical review points out, more often than not, individual Indians who chose to leave reservations did so because they could not find jobs, or decent housing, or a quality education there. Moreover, many were practically forced to leave by BIA insistence, and in this situation the Federal responsibility is certainly clear.

[9] See ch. 4 for a complete discussion of the Federal trust responsibility.
[10] See U.S. v. Holliday, 70 U.S. 407 (1865).
[11] E.g., Board of County Commissioners v. Seber, 318 U.S. 705 (1943).
[12] Winters v. U.S., 207 U.S. 564 (1908).

Most importantly, Federal policy should not be based on the Government's intention to dictate any group's culture. In discussing Indian policy, of course, this point becomes crucial. Assimilation has not succeeded and has largely been discarded. For urban Indians, however, there are many residual administrative obstacles which was constructed on the theory that off-reservation Indians gave up their tribal status, or should have given it up. The overwhelming majority of Indians in this country continue to be tribal members, regardless of where they live and regardless of whether or not their tribe is recognized by the Federal Government, and in spite of continuous policies aimed at destroying tribal society. The Federal Government's trust obligation to Indian tribes should extend to these tribal members as well as to their reservation brothers for there is no sound legal or political reason to discriminate against them.

No court, no general act of Congress, certainly no constitutional provision states that the Government's special responsibility to the Indian people stops at the reservation gate. The concept of trust responsibility is most often applied in the context of recognized reservation Indians, but several court decisions have found that the Government's legal duty is not so limited. For example, to benefit from the Federal responsibility to protect trust lands, the individual Indian need not reside on a reservation;[13] it makes no difference that he is a United States citizen as well as a tribal member, for "citizenship is not incompatible with tribal existence or continued guardianship."[14]

The unique need of nonreservation Indians has not been totally ignored in modern legislation,[15] but much of the intent of those Acts has been circumvented either by administrative neglect or outright refusal to provide services targeted to Indians.

Before 1921,[16] there had been no specific authorization for the appropriation and expenditure for most of the programs which the Bureau of Indian Affairs had come to maintain for the benefit of Indians. In the Congress, appropriations for the Bureau of Indian Affairs were subject to a point of order objection which frequently resulted in cumbersome and time-consuming maneuvering while Indian programs hung in suspense. This frustrating process was at least partially

[13] Nori v. U.S., 293 U.S. 548 (1931).

[14] U.S. v. Nice, 241 U.S. 591, 598 (1917).

[15] E.g., sec. 302 of the Comprehensive Employment and Training Act of 1973, 87 Stat. 839, makes nonreservation Indian groups and organizations eligible as prime sponsors in manpower programs.

Under the Native American Programs Act of 1974, 88 Stat. 2323, the Office of Native American Programs in the Department of Health, Education, and Welfare has the objective to provide direct support for self-determination programs aimed at improving the health, education, and welfare of Native Americans both on and off reservations. Legislative history of the Act suggests that Congress intended ONAP to expend the largest share of its budget on programs for nonreservation Indians. Analysis of ONAP grants, however, indicated that approximately 80 percent of its budget is going to reservations.

Public Law 93-638, passed on Jan. 4, 1975 (88 Stat. 2203) also includes nonreservation Indians as eligible contractors under the provisions of the Act by defining a tribal organization as any "recognized governing body of any Indian tribe" or "any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization . . ." sec. 4(c).

The recent passage of P.L. 94-437, title V, indicated the Federal Government's recognition of the urban Indian's health problem; however, rather than solving the problem, it highlights many of the complex issues surrounding urban Indian health care. As well as other issues, P.L. 94-437 highlights the following needs: (1) identification of all public and private health service resources within the urban center which may be available to urban Indians; (2) assistance of urban Indians in becoming familiar with and utilizing such resources; and (3) provision of basic health education to urban Indians.

[16] 25 U.S.C. 13.

achieved by passage of the Snyder Act which authorized items of appropriations in nine broad program areas:

> The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:
>
> General support and civilization, including education.
>
> For relief of distress and conservation of health.
>
> For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of water supplies.
>
> For the enlargement, extension, improvement, and repair of the buildings and grounds of existing plants and projects.
>
> For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges and other employees.
>
> For the suppression of traffic in intoxicating liquor and deleterious drugs.
>
> And, for general and incidental expenses in connection with the administration of Indian Affairs.

A pertinent interpretation of the Act was made in December, 1971, by Assistant Solicitor for the Division of Indian Affairs, Department of the Interior, Charles Soller. In that written opinion to the Commissioner of Indian Affairs, Mr. Soller stated that: "On its face, the underscored language is abundantly clear and requires no interpretation. Literally, it authorizes the expenditure of funds for the purposes within the named program categories for the benefit of any and all Indians, of whatever degree, whether or not members of federally recognized tribes, and without regard to residence so long as they are within the United States * * *. With language so unequivocal, it is subject to the general rule of the law that plain and unambiguous statutory language will be followed * * *."[17] The opinion states that the Snyder Act will support a broader eligibility for Bureau services, but it cautions the Bureau against extending BIA services to all Indians without first considering other "statutory limitations"[18] and without first consulting with appropriate congressional committees. Apparently, however, the Bureau never got a chance to take those other two steps because the Commissioner received specific instruction from the then Assistant Secretary, Harrison Loesch, not to divert the Bureau's "attention and limited funds from our basic responsibility of serving on-reservation Indians."[19]

Not only was the rationale weak which the Assistant Secretary presented for this limitation of services, but the statement itself shows a lack of understanding. He apparently understood that no off-reservation Indians were receiving Bureau services, except in special hardship cases. But, as explained in considerable detail by the Supreme Court in *Morton v. Ruiz*, the provision of BIA services "clearly has not been limited to reservation Indians" only.[20] Native Americans in Oklahoma and Alaska have received and still are receiving certain services from the BIA, whether they reside on or off the reservation.

[17] U.S. Dept. of the Interior, Office of the Solicitor, Scope of the Snyder Act of Nov. 2, 1921, 42 Stat. 208, 25 U.S.C. sec. 13, memorandum of Commissioner of Indian Affairs from Solicitor Division of Indian Affairs, Dec. 9, 1971.

[18] Ibid.

[19] U.S. Dept. of the Interior, Office of the Assistant Secretary, Adherence to Our Long-Standing Policy of Not Providing Special Bureau of Indian Affairs Services to Off-Reservation Indians, Memorandum from Asst. Secretary for Public Land Management Harrison Loesch, to Commissioner of Indian Affairs, Jan. 16, 1970.

[20] 415 U.S. 199, 212 (1974). This is also true for services provided by the Indian Health Service.

The Indian relocation program and general assistance benefits connected with that program are extended to nonreservation Indians.[31] Special vocational training programs have long been made available to off-reservation Indians.[32] Educational services had similarly been extended to them by virtue of the Johnson-O'Malley Act.[33]

It is true that the Court in the *Ruiz* case did not interpret the Snyder Act as *requiring* the Bureau to provide its social services program benefits to all Indians. But it is equally true that the decision interpreted the Snyder Act in broad enough terms so that such an application would be permissible. It stated that:

> We need not approach the issue in terms of whether Congress intended for all Indians, regardless of residence and of the degree of assimilation to be covered by the general assistance program. We need only ascertain the intent of Congress with respect to those Indian claimants in the case before us.[34]

Thus, the Court chose to avoid a definitive judgment on the overall issue by limiting its holding that the Bureau of Indian Affairs has the duty to provide general assistance services to Indians living "on or near the reservation" and who maintain close economic and social ties to the reservation. In spite of this requirement, BIA Manual still blatantly states that it limits eligibility to "on-reservation" Indians plus Oklahoma Indians and Alaskan Natives.[35]

The persistent refusal of the Bureau of Indian Affairs to address the problems of off-reservation Indians and to accept responsibility for fostering programs which will meet the needs of these Indian people, underscores a very basic discrepancy in the United States Indian policy.

The agent entrusted to carry out the trust which the United States assumes in its relationship to Indian people, should be eager to carry out that trust in whatever area it may encompass. To deny the rights of Urban Indians is to question the position of all Indians in United States policy. As Syd Bean, Executive Director of the Phoenix Indian Center testified at a Task Force Eight hearing, "if the off-reservation Indian communities are forced to terminate their rights for special Indian services then the Federal Indian relationship is threatened for all Indians."[36]

The Urban Environment and Urban Solution

Between the intentions of the lawmakers and the reality of regulatory actions lies the service gap that confronts the urban Indian. The result is untold desperation and waste of human resources.

Most Indians who migrate to the cities say they would have preferred not to do so at all. Still, the census figures for the years 1960-1970 show a rate increase of from 30 to 45 percent, and an HEW report published in 1970 sheds some light on the reasons.[37] The report

[31] 25 U.S.C. sec. 471. See Morton v. Ruiz, 415 U.S. 199 (1974).
[32] Morton v. Ruiz, 415 U.S. 199 (1974).
[33] 25 U.S.C. sec. 452.
[34] 415 U.S. 199, 211 (1974).
[35] 48 Indian Affairs Manual, sec. 8, 4. See generally, V. Delaria, Jr., "Legislative Analysis of the Federal Role in Indian Education," contract for the Dept. of Health, Education and Welfare, 1975.
[36] Written testimony submitted by Syd Bean at a hearing conducted by Task Force Eight, Feb. 8, 1976, p. 14.
[37] "A study of Selected Socio-Economic Characteristics of Ethnic Minorities Based on the 1970 Census: vol. III, American Indians," Office of Special Concerns, Office of the Assistant Secretary for Planning and Evaluation, Dept. of HEW, 1974.

showed that the most apparent shift from reservation to city was among those of prime employment age, between 20 and 40. It also showed that older Indians—those beyond the age of peak employment—moved back to their reservation. The report concluded that the lack of job opportunities in rural and reservation areas lent impetus to the migration.

The survey and results of the hearings by Task Force Eight affirmed that most Indians move to urban areas with hopes for jobs or for finding better jobs than on the reservation and rural areas.[38]

Regrettably, this expectation has often remained for the most part unfulfilled. The HEW report suggests that low employment may be due to inadequate vocational training,[39] a conclusion supported by the Commission's finding in two areas. One is that educational facilities on reservations are limited in standard, and the reservation is where most Indians receive their education. The other is that Indians who are educated in programs initiated outside the BIA often find that the skills they learn are not salable, and that job placement activities are limited. To date, employment assistance has been geared toward placing Indians in low-paying, entry-level jobs, rather than orientation and training for positions that could lead to upward mobility.

It has only been in the last 5 years that the BIA has ostensibly changed their former "relocation" policies. The new thrust, announced by Commissioner Louis R. Bruce in 1972, was a policy advocating for the end of termination era programs. Some of the more imaginative uses of employment assistance funds has followed emphasizing on-reservation training for tribal economic programs. Unfortunately, this emphasis is too late for those Indians who have employment and social problems in the cities.

The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the service gap reveals itself again. Ineligible for Indian Health Service assistance because he is off the reservation, the urban Indian finds that other means of finding medical attention are closed off as well.

Non-Indian health service hospitals are often reluctant to admit Indian patients for fear they will not pay. Local welfare agencies and charitable organizations often have the same fear, compounded by a belief that all Indians are the responsibility of the Federal Government. These agencies already juggle funds and personnel to serve as many needs as possible and often deny Indians treatment entirely or serve them in a superficial way.

Yet, the urban Indian often has special problems requiring treatment that is costly, prolonged and, to be successful, must be based on understanding of complex sociological factors. Two examples are the high incidence of both alcoholism and drug abuse. Both leave the urban

[38] Response from 62 organizational questionnaires regarding the needs of urban Indian communities showed employment needs for the most frequently mentioned and respondents characteristically mentioned this before any other.
[39] Ibid. HEW report, p. 51.

Indian not only in wretched physical condition, but also in danger of social repercussions, jail, and repeated fines.

Few alternatives exist in the areas of housing. Urban Indians, unschooled in rents, mortgages, or leases because of their lives on the reservation, are often targets for unscrupulous and dishonest landlords. Lacking preparation, orientation, and money, the Indian often finds himself in overpriced, substandard housing located in marginal neighborhoods.

If he tries to ease the financial and emotional burdens by sharing living quarters with another family, the results are often unsatisfactory. Overcrowding and unhealthy living conditions are two immediate results, and harrassment from landlords is almost certain to follow. Families in particular often become discouraged at this point and return to the reservation, remaining only until resources are exhausted to try the cities once again.

This back-and-forth migration works to the Indian's disadvantage. The task of gathering information that will document the problem is difficult and programs that could be funded by grants are hard to justify. It also limits the experience of social welfare agencies with unique Indian problems. Thus it becomes hard for these agencies to become conversant with the specific problems and to assist Indians accordingly, even if funds and staff were available.

One solution has been proposed and tried, with some success. Until recently, the Snyder Act provided for equity grants to be used in making downpayments on homes. These grants were available to relocates who remained in the same city for 3 to 5 years. The programs was recently cut back, a casualty of economic pressures that have reduced funding for social service programs. Reinstituting it would be highly effective, particularly if it were extended to all Indians.

THE URBAN CENTERS

In this bleak picture, the only real source of help for city Indians has been the urban centers that grew spontaneously out of informal Indian community get-togethers. Indians who moved to cities found that they shared many of the attitudes and the problems of other urban Indians. Across tribal differences, they immediately established friendly ties with Indians who were already established in the city and sought to help Indian newcomers as they moved into the city. Eventually, this feeling of comradeship inspired the idea that Indians could help each other out if they organized Indian Community Centers. These centers called "urban centers" present a number of options for Indians facing the urban world. Unfortunately, the Federal Government has failed to recognize the significance and utility of these centers for administering, or assisting in, the implementation of Federal programs for urban Indians.

For newly arrived urban Indians, the center's first function is to provide emergency care. This care may range from provision of food and clothing to finding housing by tracking down relatives or keeping up with available apartment and home listings. After dealing with these emergencies, services run the gamut from education to health care to psychological assistance.

It should be emphasized that urban Indians have done much to add to the cultural diversity and richness of many of the communities in which they live. Many cities have become justifiably proud of the Native American population. As a matter of fact, cities like Los Angeles have set the pace with support of Mayor Tom Bradley and other city officials in advocating for their Indian residents. Since this is particularly a discussion of the rule rather than the exception, we must say that the city of Los Angeles is one of the rare exceptions.

The reader should not suppose that each urban area is serviced by a highly integrated and consolidated agency called an "Indian Center." In many locations, this is a recent effort. In others, Indian centers have existed and worked with many other Indian organizations for a number of years. As Thomas Greenwood, acting president of the Indian Health Service, Inc., of Chicago, Ill., stated in his comments on the American Policy Review Commission's tentative final report:

> In Chicago and probably in many other cities as well, a network of more than twenty Indian organizations services the total population. Several are very general and includes in the programs that they offer; others concentrate on specific issues * * *. The reasons for the multiplicity of organizations are complex—relating to administrative convenience, tribal divergence, certain peculiarities in traditional modes of organization and attitudes toward power, circumstances in funding, and accidents of history. It is not clear whether a single comprehensive agency handling Indian programs in a given city is feasible—or desirable. To designate "Indian Centers" as the recipient of funds without considering the question is simply to invite problems.

Suffice it to say, however, that the model center providing multiple services seems to be the most efficient and practical method of delivering assistance whether run by one Indian center board of directors or by a board of several participating organizations.

Centers in many cities have set up educational programs, organized job banks and given moral support to those seeking employment. However, efforts are impeded because there is no mechanism for coordination of BIA vocational training programs. Though urban centers keep up to date lists of job opportunities, this knowledge is not used as the basis for the BIA vocational training program. Thus the BIA may train welders in cities offering opportunities for computer programers. Indians themselves have organized more innovative approaches to finding jobs in the city.

The Bureau of Indian Affairs continues to support Employment Assistance Offices in most cities with large Indian populations. Yet, these offices do not work with "unofficial" urban centers which are the point of contact for most Indians seeking work. BIA Employment Assistance is one of the most needed services for urban Indians, but ironically most urban Indians do not meet eligibility requirements. It is extremely unfortunate in that Federal programs neglect to use grassroots solutions to this problem.

The most difficult off-reservation service is health care. Physical requirements for facilities and fiscal requirements for personnel make it difficult for the urban center to attempt primary care, let alone the specialized therapeutic services that Indians need. Though Public Law 94-437, title V indicated the Government's recognition of the problem, it set up criteria for assistance that are difficult to fulfill.

The law states that an urban center must "determine the Indian population which are or could be recipients of health referral or care services . . ." and "identify gaps between unmet health needs of urban Indians and the resources available to meet such needs." The problem, of course, is the migratory patterns of urban Indians who, defeated by the lack of opportunities available to them in either reservations or cities, often move back and forth from reservation to urban center. Because population determinations are the basis upon which aid is provided, urban Indians are once again short changed.

NEW COMMUNITIES AND CONTINUING SERVICES IN NEW ENVIRONMENTS

Perhaps the most important contribution of the urban centers to the Indian living in cities has been a psychological one. Having left the tribal community, and often, their families, Indians feel isolation and loneliness. They developed these centers as places where such needs are partly satisfied and where they can join together in social gatherings that substitute for the personal security of the reservation. Some of the centers have evolved from very small groups organized for recreational purposes into multifaceted operations capable of sustaining programs in education and vocational training, defense of tenant rights against unscrupulous landlords, counseling, various kinds of entertainment and the provision of emergency relief. There can be no doubt that these Indian service and cultural organizations are a firmly based and creative response to Indian problems.

The Indian service centers present an ambitious range of services and objectives.

Unfortunately, they must rely on donations and volunteer work. Moreover, leaders who operate these centers are often volunteers and usually overworked. They serve out of a feeling of responsibility to the Indian community. While this is one of the dynamic and inspiring aspects of the development of urban centers, it has an unfortunate long-term effect in that there are necessarily frequent changes in leadership. While individual centers may expand or collapse, it is important to realize that the majority of urban centers have provided, and are continuing to provide, valuable services to people who are inadequately assisted through other channels. Moreover, they provide these services without usurping the relationship of the individual Indian to his tribe. The centers strengthen the urban Indian's ties to his cultural heritage by providing necessary facilities and services within an Indian setting. These organizations reinforce, rather than destroy, Indians' identification with their tribes and their heritage.

Because of the broadbased, highly sensitive services these urban centers provide, the Commission believes that their role in assisting Indians should be strengthened with trained staff and money. The Federal Government should realize that urban centers, created seperately and directed by Indians themselves, are an effective instrument for reaching the Government's goals of assisting urban Indians.

Indian centers suffer from a lack of management information and procedural standards. Like their reservation-based counterparts, tribal governments, they are often expected to know the rules when they do

not have them and to live up to unexplained standards. Provision of data on ways to effectively organize and manage the delivery of human services would be of great assistance in enriching the role for urban centers.

Fiscal and management assistance is necessary if these centers are to provide the kind of service that will enable their people to live productive lives. This assistance should be administered in several ways.

In employment, the most expedient way to provide assistance is to build on the philosophy of Indians operating Indian programs. This would entail turning over BIA Employment Assistance Offices and their programs to urban centers.

Furthermore, it would provide an administrative base necessary for an urban assistance program. Administration could be carried out by existing urban Indian centers in close cooperation with tribal governments.

The Commission devoted a great deal of time to studying this alternative. Part of the study involved contacting urban center directors. While many directors felt the centers could administer funds the best, they acknowledged that tribal governments should also play an important role. As these governments stabilize politically and economically, they could be practical mechanisms for managing funds for their own membership.

Many programs now directly administered by Federal, State, or local governments are often contracted out to private or public organizations. These are contract awards for urban services which would not be otherwise allocated to Indian tribes. Urban Indian organizations, however, are frequently discriminated against in these kinds of situations, and private non-Indian contractors benefit from contract opportunities which should properly be delegated to Indian professional people. Indian service centers, once given the opportunity and clear identification of the obligations that go with it, are very capable of hiring professionally qualified personnel.

RECOMMENDATIONS

The Commission recommends that:

1. The executive branch of the Federal Government conduct a detailed examination of assistance programs and need areas that would be most expeditiously administered by tribal governments.

2. The executive branch provide for the delivery of services to off-reservation Indians consistent with the Federal obligation to all Indians. Accordingly, Congress recommend that the executive branch deliver appropriate services when feasible through urban Indian centers.

URBAN CENTERS

3. The executive branch provide financial support for Indian centers in urban areas. This could be expedited by turning over BIA Employment Assistance Offices and other Federal contracting opportunities to urban service centers; and delegating Federal domestic assistance to Indians directly to urban centers on a fair per capita share basis.

4. The executive branch consider the placement of Federal fun targeted for urban Indians under an Urban Indian Office as a p of their considerations for the Consolidated Independent Indi Agency.

5. The Federal agency funding such urban center or centers dete mine the actual representation of such center or centers according a process of membership certified to the agency.

EDUCATION

6. The executive branch mandate that urban centers receive:

Specific consideration for the receipt of Johnson-O'Mall funds;

Technical assistance and orientation in programing, budgetin regulations, and funding programs;

Specific roles in program and policy formation in curricul development for teaching and administrative staff hiring f schools with Indian children;

Funding for administrative and program costs.

HOUSING

8. The executive branch mandate that urban Indian centers be su ported to provide:**

A real estate clearinghouse to provide information on availab living quarters;

Consumer education programs in the areas of credit procedur lease information, and general advice on moving from the res vation to an urban area;

Grants for initial moving costs, immediate support, rent su plements, housing improvements; and

The Bureau of Indian Affairs reestablish the program forme funded providing equity grants for downpayments to urban I dians who have lived in the city for more than 2 years.

HEALTH

9. The executive branch mandate that appropriate action be tak to provide urban Indians with health care facilities by providing t urban Indian center with funds to:

Administer Indian health care programs;

Provide information for health care;

Contract for Indian health care;

Establish health educational programs;

Establish health care programs on its premises; and

Act as a monitor for funds designated for urban Indian hea care.

** These funds are presently provided to the Bureau of Indian Affairs for the s purpose.

539 66-000 59

Exhibit D

Health Status of Urban American Indians and Alaska Natives

A Population-Based Study

David C. Grossman, MD, MPH; James W. Krieger, MD, MPH; Jonathan R. Sugarman, MD, MPH; Ralph A. Forquera, MPH

Objective.—To use vital statistics and communicable disease reports to characterize the health status of an urban American Indian and Alaska Native (AI/AN) population and compare it with urban whites and African Americans and with AI/ANs living on or near rural reservations.

Design.—Descriptive analysis of routinely reported data.

Setting.—One metropolitan county and seven rural counties with reservation land in Washington State.

Subjects.—All reported births, deaths, and cases of selected communicable diseases occurring in the eight counties from 1981 through 1990.

Main Outcome Measures.—Low birth weight, infant mortality, and prevalence of risk factors for poor birth outcomes; age-specific and cause-specific mortality; rates of reported hepatitis A and hepatitis B, tuberculosis, and sexually transmitted diseases.

Results.—Urban AI/ANs had a much higher rate of low birth weight compared with urban whites and rural AI/ANs and had a higher rate of infant mortality than urban whites. During the 10 years, urban AI/AN infant mortality rates increased from 9.6 per 1000 live births to 18.6 per 1000 live births compared with no trend among the other populations. Compared with rural AI/AN mothers, urban AI/AN mothers were 50% more likely to receive late or no prenatal care during pregnancy. Relative to urban whites, urban AI/AN risk factors for poor birth outcomes (delayed prenatal care, adolescent age, and use of tobacco and alcohol) were more common and closely resembled the prevalence among the African-American population except for a higher rate of alcohol use among AI/ANs. Compared with urban whites, urban AI/AN mortality rates were higher in every age group except the elderly. Differences between urban whites and AI/ANs were largest for injury- and alcohol-related deaths. All-cause mortality was lower among urban AI/ANs compared with rural AI/ANs and urban African Americans, although injury- and alcohol-related deaths were higher for AI/ANs. All communicable diseases studied were significantly ($P<.05$) more common among urban AI/ANs compared with whites. Tuberculosis rates were highest in the urban AI/AN group, but rates of sexually transmitted diseases were intermediate between urban whites and African Americans.

Conclusions.—In this urban area, great disparities exist between the health of AI/ANs and whites across almost every health dimension we measured. No consistent pattern was found in the comparison of health indicators between urban and rural AI/ANs, though rural AI/ANs had lower rates of low birth weight and higher rates of timely prenatal care use. The poor health status of urban AI/AN people requires greater attention from federal, state, and local health authorities.

JAMA. 1994;271:845-850

From Harborview Medical Center (Drs Grossman and Krieger), the Departments of Pediatrics (Dr Grossman), Medicine (Dr Krieger), and Family Medicine (Dr Sugarman), School of Medicine, the Department of Health Services, School of Public Health (Dr Grossman), and the Native American Center of Excellence (Drs Grossman and Sugarman and Mr Forquera), University of Washington; the Seattle-King County Department of Public Health (Dr Krieger); the Division of Research, Evaluation, and Epidemiology, Portland Area Indian Health Service (Dr Sugarman); and the Seattle Indian Health Board (Mr Forquera), Seattle, Wash.

The views expressed in this article do not necessarily represent the views of the Nesholm Family Foundation or the Indian Health Service.

Reprint requests to Harborview Medical Center, 325 Ninth Ave, ZX-10, Seattle, WA 98104-2499 (Dr Grossman).

IT IS generally known that the health status of American Indians and Alaska Natives (AI/ANs) is far below that of other Americans.[1] However, this conclusion is based on statistical reports from the Indian Health Service (IHS), an agency of the Public Health Service, and tribally owned health programs on or near Indian reservations or Alaska Native lands. Little is known about the health status of urban AI/ANs despite the fact that 56% of the AI/ANs identified in the 1990 US Census now reside in urban areas.[1] The IHS was created by Congress and is currently directed to "assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy."[2] Congress recently established health status objectives specifically for AI/ANs that are to be accomplished by the year 2000.[3] Funding and politics have restricted most IHS activities to tribal members living on or near Indian reservations or Alaska Native lands.

Very little health information is available regarding AI/ANs in urban areas.[4] Most published studies of urban Indian health are based on data from clinics and hospitals and cannot be generalized to an entire urban AI/AN population.[5] In a comprehensive report on Indian health published in 1986, the Office of Technology Assessment concluded that "the IHS does not collect diagnostic patient care information from urban programs and does not analyze or publish vital statistics or population characteristics for urban AI/ANs except when these data are included with national level data on the reservation states."[6] Since the publication of this report, there have not been any large population-based studies that broadly describe the health status of any urban Indian population.

The purpose of this study was to use available vital statistics and health data to characterize the health status of the AI/AN population in the largest metropolitan county within the state of Wash-

ington and to compare its health status with three reference populations. The comparison populations are the white and African-American populations within the same metropolitan county and the AI/AN population living in rural Washington counties with tribal reservations.

METHODS

Site

According to the 1990 US Census, the Seattle, Wash, metropolitan area has the seventh largest concentration of urban AI/ANs in the United States. King County, Washington, is a large metropolitan region with a population of 1 507 319.[2] There are three cities with more than 50 000 residents, the largest of which is Seattle. The 17 305 AI/AN residents comprise 1.1% of the King County population and 21% of the state's AI/AN population. Of the King County AI/AN residents, 1461 (8.4%) reported that they were of Eskimo or Aleut ancestry on the census. Data sets from which numerator data were derived do not allow stratification of Alaska Natives from American Indians. Within King County, there is one small reservation with a tribally operated clinic. The Seattle Indian Health Board, one of 34 nonprofit organizations partially funded by the IHS, operates a comprehensive community-based primary care program that cares for AI/ANs.

Comparison Groups

First, we compared the health status of AI/ANs with that of whites and African Americans within King County. Second, we compared health status indicators of the King County AI/ANs ("urban" AI/ANs) with those of AI/AN residents of rural Washington counties with tribal reservations, a population traditionally served by the IHS. These seven counties are classified by the Washington State Department of Health as "rural" (15 to 100 persons per square mile) or "remote rural" (<15 persons per square mile) counties and have reservation land belonging to federally recognized tribes. King County and the rural reservation counties account for 40% of the state's total AI/AN population. The remainder of the state's AI/AN residents live in other urban/metropolitan counties or rural counties without reservations.

Data Sources

Three main data sources were used to generate numerator data for vital statistics rate calculations. These included birth certificates, linked infant birth and death certificates, and death certificates from 1981 through 1990 from the Center for Health Statistics of the Washington State Department of Health. Communicable disease data were obtained from the Centers for Disease Control and Prevention and the Epidemiology Office of the Washington State Department of Health. Data from the 1980 and 1990 editions of the US Census provided the denominator and socioeconomic data for each of the comparison groups. Population estimates for urban and rural AI/ANs between 1980 and 1990 were generated by linear interpolation between 1980 and 1990 US Census counts while estimates for urban whites and African Americans were based on Washington Office of Financial Management demographic estimates. These Office of Financial Management estimates were unavailable for all counties in the study, so all AI/AN denominator estimates were derived using linear interpolation. The differences between the two denominator estimates (for the intercensus period) were quite small. The interpolation method gave a slightly higher number for each of the years, with a range of ratios from 1.02 to 1.06. This method consistently exceeded the Office of Financial Management estimate and resulted in a probable underestimate of mortality rates of urban AI/AN residents compared with other races.

We used the post-1989 National Center for Health Statistics definition of race for all infant birth and death rate calculations in the study. The National Center for Health Statistics currently defines an AI/AN birth as an infant born to a mother identified in the birth record as AI/AN, regardless of the father's race. We used linked birth and death certificates for infants in which the mother's race at birth defines the race at birth and death. Individuals self-report their race to the US Census.

Health Status Measures

The health status indicators used in this study were derived from routinely collected population-based health status data for which race-specific information was available. Mortality rate calculations included infant mortality, age-specific mortality rates in six age groups, cause-specific mortality, and alcohol-associated mortality. To assess alcohol-associated mortality, alcohol-related disease impact software was used.[7] This methodology, developed by the Centers for Disease Control and Prevention, uses the attributable risk from alcohol use for each cause of death to derive a composite rate of alcohol-associated mortality.

Maternal and infant health measures included the proportion at birth of preterm births (<37 weeks' gestational age), of low (<2500 g) and very low (<1500 g) birth weight, of unmarried mothers, of mothers who started prenatal care in the first trimester (on time care) or who had late (third trimester) or no prenatal care, and of mothers who smoked tobacco or consumed alcohol during pregnancy, and the school-age (ages 10 through 17 years) fertility rate. The data source for information on smoking and alcohol use during pregnancy and prenatal care was the birth certificate. Smoking data from 1986 through 1988 were used (question wording on Washington State birth certificates was changed in 1989). Assessment of alcohol consumption was added to the birth certificate in 1989. Maternal drug-use data are not routinely collected on Washington State birth certificates.

Because the AI/AN population is small, only reportable communicable diseases of high frequency were compared. These included sexually transmitted diseases (gonorrhea, syphilis, and chlamydia), tuberculosis, and hepatitis A and hepatitis B. Because detailed data for sexually transmitted diseases were unavailable for rural counties, these data were used for comparisons within King County only.

We used the following *International Classification of Diseases*[8] codes as definitions for cause-specific mortality: heart disease, 391 through 392.0, 393 through 398, 402, 404, 410 through 416, 420-429; cancer, 140-208; unintentional injury, E800 through E949; liver disease, 571; cerebrovascular disease, 430 through 434, 436-438; pneumonia and influenza, 480 through 487; homicide, E960-E969; diabetes, 250; chronic obstructive pulmonary disease, 491, 492, 496; suicide, E950 through E959; and all firearms, E922, E955.0 through E955.4, E965.0 through 965.4, E870, E985.0 through E985.4.

All disease and death rates were age-adjusted to the 1940 US population for

Table 1.—Demographic Characteristics of Study Populations

Characteristic	Urban			Rural
	AI/AN*	White	African American	
1990 population	17 305	1 [illegible]	72 463	[illegible]
Older than 25 years without high school diploma, %	24	10	21	24
Unemployed, %	8.4	3.7	11.3	21
Below 100% of federal poverty level, %	28	6.1	22	26

*AI/AN indicates American Indian and Alaska Native.

Table 2.—Prevalence of Risk Factors for Poor Birth Outcomes Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

	Average Rates 1988 Through 1990 (Total Births)*			
	Urban			
Risk Factors	AI/AN (n=[illegible])	White (n=[illegible])	African American (n=[illegible])	Rural AI/AN (n=1081)
Low birth weight (<2500 g)	8.8 (7.7-11.8)	5.0 (4.9-5.2)†	13.0 (12.0-14.1)†	5.6 (4.3-7.2)†
Very low birth weight (<1500 g)	1.8 (1.0-2.7)	0.8 (0.7-0.8)†	2.8 (2.4-3.4)	0.8 (.35-1.7)
Preterm births (<37 wk gestation)	15.9 (13.5-18.8)	8.1 (7.9-8.4)†	17.7 (16.5-19.1)	13.0 (10.8-15.8)
Mother 10-17 y of age	8.1 (7.4-11.1)	1.7 (1.6-1.8)†	6.8 (5.0-10.8)	10.2 (8.5-12.2)
Single mother	59.1 (55.0-62.1)	15.7 (15.4-16.0)†	65.1 (63.6-66.6)†	64.6 (61.8-67.3)
Consumed alcohol‡	20.1 (16.3-24.4)	6.2 (5.9-6.5)†	11.0 (9.5-12.7)†	15.3 (13.5-19.3)
Smoker§	36.2 (34.7-41.7)	20.0 (18.7-20.4)†	32.5 (31.9-36.0)	40.6 (37.5-43.8)
Received first-trimester prenatal care	56.5 (53.1-60.0)	83.9 (83.6-84.2)†	59.2 (57.5-60.8)	64.0 (61.0-67.0)†
Received late or no prenatal care	15.9 (13.5-18.5)	3.4 (3.3-3.6)†	12.7 (11.6-13.9)	10.0 (8.3-12.0)†

*Data expressed as percentage (95% confidence interval). Infant race determined by mother's race on birth certificate. Urban AI/ANs are the reference group for all statistical comparisons.
†Significantly ($P<.05$) different from urban AI/AN rate.
‡Two-year average rates, 1989 through 1990.
§Three-year average rates, 1988 through 1990.

two reasons. A recent Centers for Disease Control and Prevention conference on age adjustment concluded that the 1940 US population would continue to be recommended by the National Center for Health Statistics as the standard population for US mortality data (primarily for purposes of comparability to historical national data).[9] Also, IHS uses the 1940 population as the reference in its annual statistical publications, widely cited sources for AI/AN health data; thus, use of the 1940 population will facilitate comparisons. Confidence intervals (CIs) for age-adjusted rates were compiled using the method of Chiang,[10] and CIs for proportional rates were calculated by the method of Fleiss.[11] Three- or 5-year rolling averages were used to assess trends, depending on the frequency of the outcome. Chi-square test for trend was used to determine the statistical significance of rate trends over time.

To determine whether the difference in low-birth-weight rates between urban and rural AI/AN populations could be entirely explained by differences in known behavioral and biologic risk factors, we conducted a logistic regression analysis to determine the model that best explained low-birth-weight variation. The outcome variable was defined as the presence or absence of low birth weight. The main independent variable was whether the birth occurred in an urban or rural location. The covariates included known maternal risk factors for low birth weight, including smoking, alcohol use, adolescent age, prior pregnancies, and the interpregnancy interval.

RESULTS

Socioeconomic Characteristics

Data from the 1990 US Census revealed that, compared with whites, the urban AI/AN population had fewer high school graduates and higher rates of unemployment and poverty (Table 1). However, rural AI/ANs appeared to be the most disadvantaged group in the study. A third of those older than 25 years living in rural counties were without a high school diploma. Unemployment (21%) and poverty rates (35%) were also highest among rural AI/ANs.

Birth Outcomes

The prevalence of low birth weight (<2500 g) was considerably higher among urban AI/ANs compared with urban whites and rural AI/ANs, but was lower than the rate of low birth weight among urban African Americans (Table 2). The prevalence of very low-birth-weight (<1500 g) births and premature deliveries shared similar patterns, although only the differences between urban AI/ANs and whites were significant.

Using low birth weight as the dependent variable and urban or rural status as the main independent variable, we found that after adjustment for the interval between births, history of prior pregnancy, adolescent age, use of prenatal care, and maternal smoking, the difference in low-birth-weight risk between the rural and urban groups was no longer statistically significant (odds ratio, 0.90; 95% CI, 0.56 to 1.4; $P=.66$). Thus, it appeared that most of the variation was attributable to differences in risk profiles of each group and not to a community risk or protective factor represented by the urban/rural variable.

Like low birth weight, the infant mortality rate averaged over 10 years was 80% higher among urban AI/ANs than among whites (Table 3). Neonatal and postneonatal mortality rates were higher among the urban AI/ANs (data not shown). Infant mortality rates among the urban AI/ANs were not significantly different than those among African Americans or the rural AI/ANs.

A significant increase in the urban AI/AN infant mortality rate occurred during the decade starting in 1981 (Figure). Five-year rolling average rates increased consistently every 5-year period from 9.6 per 1000 live births during 1981 through 1985 to 18.6 per 1000 during 1986 through 1990 (χ^2 test for trend, 5.1; $P<.05$). This decade-long trend was not evident among the other county residents or the rural population. The apparent upward trend among African Americans was not significant.

Prenatal Risk Factors for Poor Birth Outcomes

Rural and urban AI/AN mothers shared a similar prenatal risk profile (adolescent age, single marital status, and use of tobacco and alcohol during pregnancy) for poor birth outcomes (Table 2). However, urban AI/AN women were less likely than rural AI/AN women to initiate prenatal care in the first trimester (56.5% vs 64.0%; $P<.05$) and more likely to have late (third trimester) or no prenatal care (15.9% vs 10.0%; $P<.05$).

Urban AI/AN mothers had a much higher risk profile in comparison with urban white mothers (Table 2). Births among mothers aged 10 to 17 years, mothers who were single, or mothers who used tobacco or alcohol during pregnancy were all more common among AI/ANs. Similarly, the lower rates of first trimester prenatal care and high rates of late (third trimester) or no prenatal care seemed to place AI/ANs at higher risk of poor birth outcomes. This risk profile closely resembled that of African-American mothers across all variables except for prenatal alcohol consumption, where the risk among AI/ANs was significantly higher.

Table 3.—Urban American Indians and Alaska Natives (AI/AN) Mortality Rates Compared With Other Races and Rural AI/AN by Age Group and Causes, 1991 Through 1995*

Mortality Rate	Urban			Rural AI/AN
	AI/AN	White	African American	
Infant (age 0-1 y), 10-y average rate, per 1000 live births (95% CI)†	14.7 (10.8-20.3)	8.0 (7.9-8.4)‡	17.5 (15.3-20.0)	23.2 (18.4-29.2)
Age-specific, y, 10-y average rate per 100 000 population (95% CI)				
1-14	56 (35-87)	29 (26.4-31.2)‡	39 (29.8-49.7)	62 (42-92)
15-24	162 (121-217)	83 (78.4-86.8)‡	131 (111.3-153.8)	305 (209-437)
25-44	235 (209-300)	127 (123.8-130.8)‡	279 (258.1-302.1)	386 (327-454)
45-64	1122 (963-1299)	650 (632.4-703.8)‡	1303 (1231.8-1378.8)	1092 (900-1256)
65-99	3009 (2605-3573)	4040 (4012.4-4094.8)‡	5158 (4951.3-5373.3)‡	5134 (4650-5543)‡
Total deaths	727	93 048	4525	821
Cause-specific, 10-y age-adjusted (to 1940) rate per 100 000 population (95% CI)				
All causes	587 (557-636)	473 (468.4-476.8)‡	729 (710.5-748.3)‡	747 (702-791)‡
Alcohol related	149 . . .	82 . . .	105 . . .	182 . . .
Heart disease	141 (120-163)	139 (137.1-140.3)	207 (195.8-217.8)‡	188 (164-212)‡
Cancer	76 (57-92)	127 (124.8-128.3)‡	175 (164.4-185.3)‡	93 (75-110)
Unintentional injury	69 (56-83)	29 (27.8-29.5)‡	36 (34.8-44.4)‡	116 (99-136)‡
Liver disease	50 (37-62)	9 (8.3-9.4)‡	15 (12.0-16.7)‡	44 (31-56)
Cerebrovascular	26 (16-35)	39 (27.7-29.1)	48 (42.3-53.1)‡	56 (42-70)‡
Pneumonia and influenza	22 (14-31)	12 (12.0-12.8)‡	13 (10.2-15.7)	15 (9-22)
Homicide	21 (14-28)	4 (3.9-4.5)‡	30 (25.7-34.0)	20 (12-27)
Diabetes	19 (11-27)	8 (7.8-8.7)‡	30 (25.4-34.3)	20 (12-29)
Chronic obstructive pulmonary disease	18 (10-26)	19 (18.5-19.8)	19 (15.1-22.1)	24 (15-33)
Suicide	17 (10-23)	14 (12.8-14.1)	9 (8.8-11.4)	20 (16-35)
All firearms	15 (9-21)	8 (7.9-8.8)‡	21 (17.3-24.2)	34 (24-45)‡

*CI indicates confidence interval. Ellipses indicate data not available.
†Based on linked birth and death files where mother's race is AI/AN.
‡Significantly different from urban AI/AN rate.

Age-Specific Mortality

Urban AI/AN age-specific mortality rates were higher in almost every age group compared with urban whites. The only exception was among the elderly (older than 65 years), in which the AI/AN rates were lower (relative risk [RR], 0.65; 95% CI, 0.56 to 0.75). The biggest difference was evident in the 25- to 44-year age group, though rates in the 1- to 14-year and 15- to 24-year age groups were nearly twofold higher than among whites. The only significant ($P<.05$) difference between urban AI/ANs and African Americans was in the oldest age group, in which rates for African Americans were higher.

Similarly, a comparison of death rates between urban and rural AI/ANs appeared to demonstrate slightly lower rates among urban AI/AN residents, although only the difference among the elderly (older than 65 years) reached statistical significance (RR, 0.60; 95% CI, 0.51 to 0.72; $P<.05$).

Cause-Specific Mortality

The overall age-adjusted mortality rate among urban AI/ANs was higher compared with whites, but lower compared with African Americans and rural AI/ANs (Table 3). Injuries and alcohol-related deaths accounted for the majority of excess mortality among AI/ANs. Urban AI/ANs had significantly ($P<.05$) lower age-adjusted all-cause mortality rates than rural AI/ANs as well as for heart disease, unintentional injury, cerebrovascular disease, and firearm injury. Rates for other specific causes of death (cancer, liver disease, pneumonia and influenza, homicide, suicide, diabetes, and chronic obstructive pulmonary disease) were not significantly different between the groups.

Within the urban county, the most striking differences in cause-specific mortality rates between AI/ANs and whites were for chronic liver disease and cirrhosis, unintentional injury, and homicide. Of the leading causes, only cancer was lower in the AI/ANs compared with whites. Compared with African Americans, the urban AI/ANs had lower all-cause death rates and lower rates from heart disease, cancer, and cerebrovascular disease, but higher death rates from unintentional injury and liver disease.

Communicable Diseases

Among communicable diseases, the prevalence of reported hepatitis A and hepatitis B was higher among urban AI/ANs than among rural AI/ANs, urban whites, and African Americans (Table 4). Similarly, urban AI/ANs also experienced a much higher reported prevalence of tuberculosis compared with all three other population groups. Reported prevalence rates of chlamydia, syphilis, and gonorrhea were much higher among urban AI/ANs compared with urban whites, but considerably lower than rates among urban African Americans. Race-specific rates of sexually transmitted diseases were not available for rural AI/ANs.

COMMENT

The findings of this study confirm the existence of great disparities between the health of AI/ANs and whites living in one large metropolitan area. Urban AI/ANs have poorer health across almost every indicator we examined. The gap appears across almost all age groups and most causes of death. Many of the indicators were similar to those among urban African Americans, a group whose health status has repeatedly demonstrated the health inequities between whites and minorities in the United States.[18]

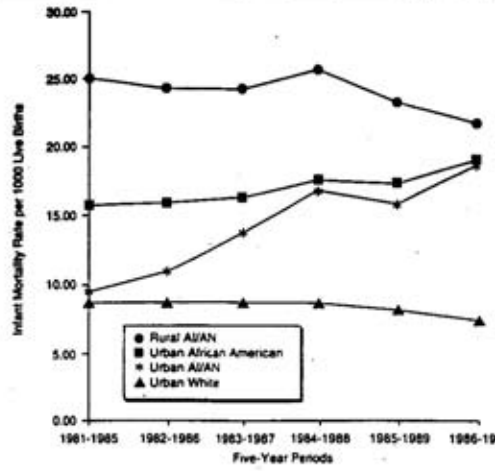
Our systematic comparison of health status indicators between urban and rural AI/ANs did not reveal a consistent pattern. Our most disturbing finding was the significant decade-long rise of the urban AI/AN infant mortality rate, a trend not shared by any of the other study populations. Rural AI/AN moth-

ers of newborn infants were more likely to have early and adequate prenatal care and were less likely to deliver a low-birth-weight infant than urban AI/AN mothers. This may be a result of access to comprehensive maternal and child health services offered by the IHS that include extensive public health nursing outreach systems. Access to these services in the rural IHS clinics may have led to earlier initiation of and follow-up with prenatal care. Though the earlier use of prenatal care and the lower rate of low birth weight appeared to demonstrate better maternal and infant health in the rural population, rural AI/AN infant mortality (including both neonatal and postneonatal mortality) was not lower in the rural counties. This surprising relationship between low birth weight and infant mortality rates may be a reflection of superior access to neonatal intensive care in the urban county.

The AI/AN mortality rates tended to be higher within the rural counties than within the urban area. The most striking age-specific difference was among the population older than 65 years. The higher rate of unintentional injury fatalities is not surprising since the incidence of fatal motor vehicle crashes is known to be higher in rural areas, especially among AI/ANs.[13] Almost all of the overall mortality difference can be explained by higher rates of the four leading causes of death (heart disease, cancer, injury, and cerebrovascular disease) among rural AI/ANs, compared with their urban counterparts.

Several limitations may have affected the results of this study. Although undercounting of AI/ANs in the census would have the effect of inappropriately increasing morbidity and mortality rates when the census population is used as the denominator, data from the 1980 and 1990 censuses suggest that the problem of undercounting of AI/ANs has diminished in comparison with earlier censuses.[14] Misclassification of race in vital records can result in substantial underestimates of mortality rates among AI/ANs.[15-17] We estimate that this differential misclassification affects mortality data by artificially minimizing some of the true disparity between whites and urban AI/ANs, ie, a conservative bias. We attempted to minimize the effects of racial misclassification for infant mortality rates and the prevalence of birth risk factors by using linked birth and death certificates and the current National Center for Health Statistics designation of race. However, estimates of AI/AN mortality rates for ages beyond infancy were not derived from linked files, raising the potential for significant racial misclassification and underestimation of the AI/AN rates. If misclassification of AI/ANs as other races was less likely to occur in rural areas (perhaps because morticians and coroners are more sensitive to the presence of a large AI/AN population), then urban rates would be selectively underestimated, thus accounting for some of the differences between urban and rural AI/ANs observed in this study. Indeed, in a study of racial misclassification of clients of the Seattle Indian Health Board, almost one third of persons who identified themselves as AI/AN to the clinic while living were classified as other races on death certificates, compared with approximately 12% inconsistent classification among primarily rural, IHS-registered AI/ANs in Washington.[18] Because the direction of this potential bias is known, study conclusions or policy implications should not be significantly affected. Data from birth certificates may be less susceptible to this potential bias.

In addition to racial misclassification on vital records, several studies in the Pacific Northwest have shown that morbidity rates calculated from registries of cancer,[19] AIDS,[20] end-stage renal dis-



Five-year rolling averages for infant mortality trends of urban American Indians and Alaska Natives (AI/ANs) compared with other races and rural AI/ANs. Data derived from linked birth and death certificates. Race classified according to maternal race.

Table 4.—Incidence of Communicable Diseases Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

Disease	Urban			Rural AI/AN
	AI/AN	White	African American	
Hepatitis A†	151 (123-178)	42.0 (39.8-44.1)‡	43.4 (34.9-52.0)‡	106 (85-128)
Hepatitis B†	47 (31-63)	10.8 (9.7-11.8)‡	25.3 (18.8-31.8)	25 (14-35)
Tuberculosis§	60 (47-74)	3.0 (2.7-3.3)‡	16.8 (13.5-20.0)‡	20 (12-28)‡
Sexually transmitted diseases‖				
Chlamydia	516 (460-573)	255.5 (250.0-261.1)‡	1472.8 (1432.9-1512.2)‡	NA
Gonorrhea	298 (253-342)	81.0 (77.9-84.2)‡	2055.5 (2008.5-2102.5)‡	NA
Syphilis	47 (28-66)	4.9 (4.2-5.6)‡	183.7 (166.0-201.4)	NA

*All rates age-adjusted to 1940 US population. NA indicates not available. Data expressed as mean rates per 100 000 population (95% confidence intervals).
†Average rate, 1987 through 1990.
‡Significantly ($P<.05$) different from urban AI/AN rate.
§Ten-year average rate, 1981 through 1990.
‖Three-year average rate, 1988 through 1990.

ease,[19] and injury[20] may be underestimated among AI/ANs because of racial misclassification. Reporting bias is another potential concern in this study, primarily in the rates of communicable diseases. Care providers in the public sector, where indigent patients are more likely to seek care, may be more likely to report cases of communicable diseases to health authorities than private practitioners. The effect of this bias would be to overestimate the differences noted between whites and urban AI/ANs with respect to communicable diseases such as gonorrhea.

Should urban AI/ANs receive attention as a population with special health needs? More than half of AI/ANs now live in urban areas, but only a few of these areas, such as Albuquerque, NM, Phoenix, Ariz, and Anchorage, Alaska, offer direct IHS services. Title V of the Indian Care Improvement Act of 1976 was the first federal government recognition of the health needs of urban AI/ANs. Despite this recognition, few resources have been allocated to address these needs. The initial 1976 authorization called for a $15 million allocation for urban Indian communities to organize programs to "facilitate access to and, when necessary, provide health services to urban Indian residents."[22] In 1992, only $17 million was appropriated to urban Indian programs in cities where an IHS facility was not present, representing 1% of the total IHS budget. Because eligibility for the full scope of IHS services has been reserved for "persons of descent belonging to the Indian community served by the local facilities and program," it effectively excludes rural AI/AN residents who move to an urban area without an IHS direct care facility, perhaps in search of employment or family reunification.[4] Though the reasons for the presence of large urban AI/AN populations are not completely known, many urban AI/AN residents were coercively relocated from reservations by the federal government to the cities during a period in the 1950s known as the "termination era" in the history of relations between US Indians and whites.[23] This relocation policy separated AI/AN people from tribal land and culture, exposing them to the harsh social and economic conditions of the urban poor. Others migrated to the cities in search of employment and education. Many of these individuals and their families never returned to their reservations. Whatever the reason, many AI/AN people are firmly rooted in the cities.

The allocation of IHS funds to the urban Indian program has been a source of controversy between urban Indian and tribal leaders. Concerned that scarce resources would be redirected from the reservations to the cities, some tribal leaders have opposed the expansion of urban programs. Our data do not support the redirection of funds previously designated for rural AI/ANs living on native lands, since it appears that both populations are vulnerable and in similar great need of health services, epidemiologic surveillance, and prevention activities. The recent drive for health system reform may benefit the health concerns of the urban AI/AN population. Under President Clinton's proposed Health Security Act of 1993 (section 8302), urban AI/ANs will be eligible for the same full health care benefits extended to rural AI/AN residents. Under this plan, all AI/AN enrollees could receive their care in an IHS, a tribal, or an urban Indian facility. Until a solution is reached in the context of health system reform, the responsibility for the health needs of urban AI/ANs must continue to be addressed at local, state, and federal levels in consultation with existing urban Indian programs.

This research was supported by a grant from the Nesholm Family Foundation, Seattle, Wash.

We thank John Kobayashi, MD, MPH, and Ernest Kimball, MPH, for their assistance with the project. We are very grateful to Abraham Bergman, MD, Lawrence Berger, MD, MPH, Thomas Koepsell, MD, MPH, and Steven Helgerson, MD, MPH, for reviewing earlier drafts of the manuscript. We are also deeply indebted to Jim Allen, Cindy Crosap, and Bi-Lan Chiong for their expert technical assistance.

References

1. Rhoades ER, Hammond J, Welty TK, Handler AO, Amler RW. The Indian burden of illness and future health interventions. *Public Health Rep* 1987; 102:361-368.
2. US Bureau of the Census. *1990 Census of the Population: General Population Characteristics—United States*. Washington, DC: US Bureau of the Census; 1990.
3. Pub L No. 102-537. Amendments to the Indian Health Care Improvement Act of 1992.
4. Kramer BJ. Health and aging of urban American Indians. *West J Med*. 1992;157:281-285.
5. Taylor TL. Health problems and use of services at two urban American Indian clinics. *Public Health Rep*. 1988;103:89-95.
6. *Indian Health Care*. Washington, DC: Office of Technology Assessment; 1986. US Dept of Health and Human Services publication OTA-H-290.
7. Shultz JM, Rice OP, Parker DL, Goodman RA, Stroh GJ, Chalmers N. Quantifying the disease impact of alcohol with ARDI software. *Public Health Rep*. 1991;106:443-450.
8. World Health Organization. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Based on the Recommendations of the Ninth Revision Conference, 1975*. Geneva, Switzerland: World Health Organization; 1977.
9. *Reconsidering Age-Adjustment Procedures*. Washington, DC: US Dept of Health and Human Services publication PHS 85-1445.
10. Chiang CL. Standard error of the age-adjusted death rate. *Vital Stat Special Rep*. 1961;47:275-285.
11. Fleiss JL. *Statistical Methods for Rates and Proportions*. New York, NY: John Wiley & Sons Inc; 1981.
12. Dept of Health and Human Services. *Report of the Secretary's Task Force on Black and Minority Health. I: Executive Summary*. Washington, DC: US Dept of Health and Human Services; August 1985.
13. Baker SP, O'Neill B, Ginsburg MJ, Li G. *The Injury Fact Book*. 2nd ed. New York, NY: Oxford University Press; 1992:234.
14. Passel JS, Berman PA. Quality of 1980 census data for American Indians. *Soc Biol*. 1986;33:163-182.
15. Hahn RA, Molinare J, Teutsch SM. Inconsistencies in coding of race and ethnicity between birth and death in US infants: a new look at infant mortality, 1983 through 1985. *JAMA*. 1992;267:259-263.
16. Frost F, Taylor V, Price E. Racial misclassification of Native Americans in a surveillance, epidemiology, and end results cancer registry. *J Natl Cancer Inst*. 1992;84:957-962.
17. Centers for Disease Control and Prevention. Classification of American Indian race on birth and infant death certificates—California and Montana. *MMWR Morb Mortal Wkly Rep*. 1993;42:220-223.
18. Sugarman JR, Hill G, Ferguson R, Frost FJ. Coding of race on death certificates of patients of an urban Indian health clinic, Washington, 1973-1988. *IHS Provider*. 1992;17:113-115.
19. Hurlich MG, Hopkins SC, Sakuma J, Conway GA. Racial ascertainment of AI/AN persons with AIDS, Seattle/King County, WA 1980-1990. *IHS Provider*. 1992;17:73-74.
20. Sugarman JR, Lawson L. The effect of racial misclassification on estimates of end-stage renal disease among American Indians and Alaska Natives, Pacific Northwest, 1988-1990. *Am J Kidney Dis*. 1993;21:283-288.
21. Sugarman JR, Soderberg R, Gordon JE, Rivera FP. Racial misclassification of American Indians: its effect on injury rates in Oregon, 1989 through 1990. *Am J Public Health*. 1993;83:651-654.
22. Pub L No. 94-437. Indian Health Care Improvement Act of 1976.
23. Prucha FP. *Documents of United States Indian Policy*. Lincoln: University of Nebraska Press; 1990:227.

Exhibit E.

URBAN INDIAN HEALTH FACTS

Urban Indians make up over 60% of the total Indian population.

Urban Indian population has grown over 30% in the last 3 decades.

Urban Indians are undercounted by the U.S. Census and not included in statistical data gathered for urban areas.

Urban Indians are dispersed throughout all census tracts in urban areas; no ghettos. As invisible minorities they are excluded from public block grants; minority assistance programs; start-up capital for businesses; and mainstream markets.

Urban Indian unemployment is double that of all other races [in some cities, like Boston, there is evidence that the Indian unemployment rate is quadruple the rate for all other races].

Urban Indian poverty levels are three times that of any other race.

Urban Indian high school drop out rate is over 75%.

Urban Indian business development rate is the lowest of any race.

Urban Indians have higher mortality rate from alcoholism and related causes than other races.

Urban Indian suicide rate is four times that of all other races.

Urban Indians have three times the national rate for diabetes and heart disease. Health care is unavailable to 50%-75% of Urban Indians.

Urban Indian mental health patients increased 200% from 1988 to 1990.

Urban Indians are citizens of both the United States and their sovereign Tribal Nation.

This fact sheet is derived from one developed by The National Urban Indian Policy Coalition.

Southern California
TRIBAL CHAIRMEN'S
Assoc., Inc.

July 23, 2000

Honorable Ben Nighthorse Campbell
United States Senate
Hart Building Room
Washington, DC 20518

Re: Written Testimony Indian Health Care Improvement Act S2526
Ben Senate Campbell

We support the hearing on S. 2526, to reauthorize Indian Health Care Improvement Act.

Problem: One of the major barriers of providing any services to Indian County is the start-up and stop of individual families services, which many services require many applications, forms, requests, and statements, for a variety of health services. Our example: one complete application for TANF Cash Assistance, one complete application for Food Stamps, one complete application for Medi-Cal, one complete application for Child Support Enforcement, and to basically six other agencies that deal with economically disadvantage, high risk families.

We need to solve the application barriers by having a cognizant agency for recipients that issue a "one stop card", as the one stop application, which basically certifies the eligibility of the individual to receive Medi-Cal, TANF (cash assistance), Food Stamps, and other Services.

We have attached a chart that better conceptualizes our One Stop Application network, for the economically disadvantage, and high risk family. We hope Senate will consider S2526, becoming a partnership into a One Stop Application process for economic disadvantage, high risk family.

Respectfully,

Ralph Goff
Tribal Chairman

Respectfully,

Dennis Turner
Executive Director

See attached Proposed Amendments.

P.O. 1470 • Valley Center, CA 92082
Ph. (760) 749-0918 • FAX (760) 749-5615

INDIAN HEALTH CARE IMPROVEMENT ACT

PROPOSED AMENDMENT

A Tribal provision in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, provided language that would allow Indian Tribes to administer a TANF (cash assistance) program.

One of the major barriers of providing any service to Indian Country is the lack of transportation. Rural public transportation systems are sporadic and in many areas non-existence. Tribal members of Tribal TANF programs must complete one application for cash assistance, travel to the local county welfare office to complete a similar application for the Federal Medicaid program.

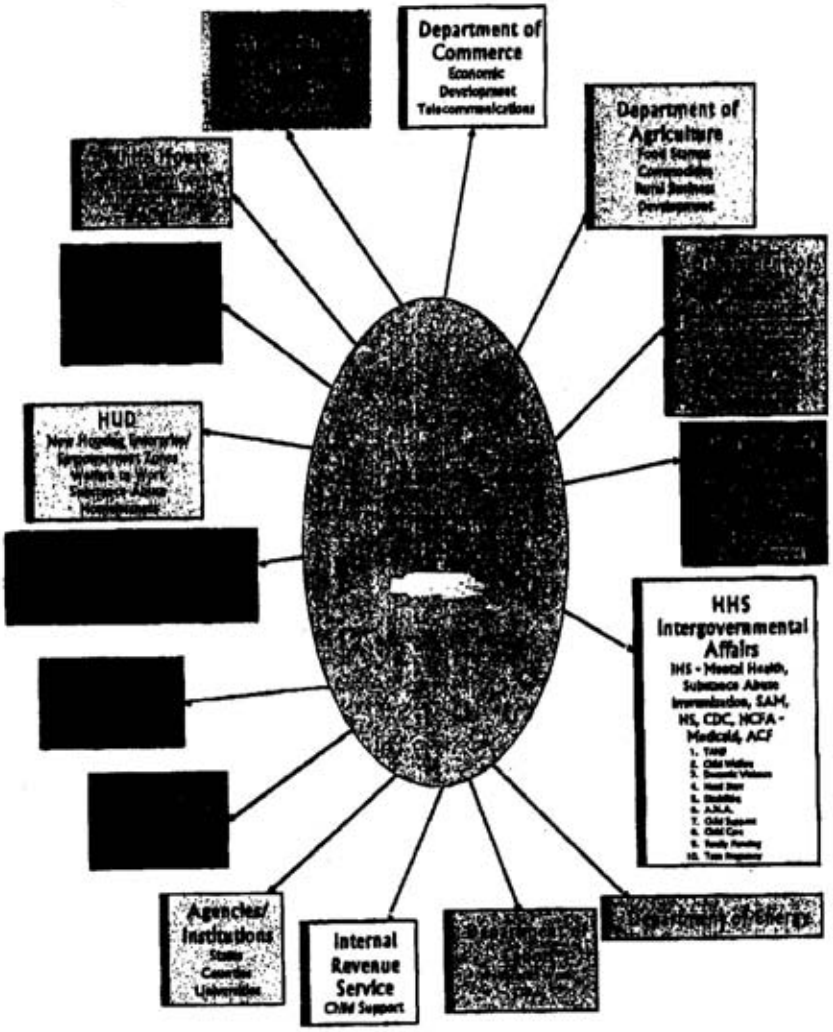
The State agency is responsible for conducting the Medicaid Program eligibility determination on Indian reservations, which historically has resulted in under representation of Indian people. .

Therefore, an amendment to the Indian Health Care Improvement Act that will allow Tribal TANF programs to determine eligibility for Medicaid program will increase Indian participation and provide a one-stop application for services.

AMENDMENT

Indian Tribes that administer a Tribal TANF program are authorized to determine eligibility for the Federal Medicaid program.

Visualizing Our Network



Health and Human Services

TANF Block Grant/New

Medicaid

Child Support Enforcement

Child Care/Head Start

Social Services Block Grant

Teen Pregnancy Prevention/Family Planning

Substance Abuse Treatment & Prevention

Mental Health Treatment & Prevention

Family Violence Programs/Violence Against Women

Children's Mental Health Services

Community Services Block Grant

Individual Development Accounts

Assets for Independence Demonstrations (to establish, Individual Development accounts for low income individuals/families)

Job Opportunities for Low Income

Community Economic Development/Rural Community Facilities

Fatherhood Programs

Department of Agriculture

Distance Learning (Funding to encourage/improve telecommunications/computer networks to provide education for rural areas)

Rural Development (Pursuing ways to stimulate improvements in the economic, social or environmental well-being of rural residents through technical and financial assistance)

Wood in Transportation (Offers technology transfer and value added business development assistance for improved transportation and infrastructure and markets for wood)

Rural Business Enterprise Grants (Help finance and facilitate development of small and emerging private business enterprises located in rural areas)

Rural Business Opportunity Grants (Provides funds for technical assistance, training/planning activities that improve economic conditions in rural areas. To promote sustainable economic development in rural communities with exceptional needs)

Food Distribution Program on Indian Reservations (Commodities)

Food Stamps (Helps low-income households but food for a more nutritious diet)

Community Facility Program (A community facility is a service center that provides essential public services such as a welfare services building)

Emergency Food Assistance Program

Child Adult Care Food Program

Community Food Projects (to meet the food needs of Low-income people)

WIC

Department of Justice

Tribal Courts

Felony/ fleeing felons criminal information

Domestic Violence (STOP Violence Against Women)

Drug Abuse Programs

Department of Treasury

Internal Revenue (Tax returns & Child Support)

Department of Education

Adult Education

Education Block Grant

Education for Disadvantaged

Special Education

Vocational Education

Child Care Access

Rehabilitation Education

Life Skills

Learning Disabilities

Even Start

Literacy Grants

Department of Labor

WIA

Adult Job Training

Welfare to Work

School to Work

Youth Opportunity Program

CHEROKEE NATION
P.O. Box 948
Tahlequah, OK 74465-0948
918-456-0671

Chad "Corntassel" Smith
Principal Chief

Hastings Shade
Deputy Principal Chief

April 7, 2000

Paul Moorehead
Majority Staff Director
Committee on Indian Affairs
838 Hart Senate Office
Washington, DC 20510

Dear Mr. Moorehead:

The Committee on Indian Affairs has scheduled a field hearing in Denver, Colorado on draft legislative *"to reauthorize the Indian Health Care Improvement Act of 1976, as amended"* for Monday December 6, 1999. We offer this letter as support for a proposed amendment to the IHCIA.

It has been brought to our attention that the language, *TANF Tribes are authorized to determine eligibility for Federal Medicaid*, was deleted from the proposed bill for the reauthorization of the Indian Health Care Impr9ovement Act (IHCIA) of 1976. By deleting the proposed amendment language from the reauthorization bill, TANF Tribes would be unable to evolve, as the States have evolved, and provide one stop programs that will ease the stress for Native American clients. The State of Oklahoma's assistance programs has been evolving for decades and have Federal statutory and regulatory relief for program development.

Tribal one-stop services will ease the stress on clients regarding transportation (a major barrier to delivery of services) and redundant and laborious program applications that need to be completed for eligibility determination.

We strongly recommend that this language be reinstated to allow tribes the flexibility to develop their own program according to their individual needs.

Sincerely,

Jerry D. Snell
Director
Family Assistance Department
Cherokee Nation

OSAGE TRIBE OF INDIANS
OSAGE TANF PROGRAM
1333 Grandview
Pawhuska, Oklahoma 74056
1-888-822-1248
918-287-1248

Paul Moorehead
Majority Staff Director
Committee on Indian Affairs
838 Hart Senate Office
Washington D.C. 20510

Dear Mr. Moorehead:

The Committee on Indian Affairs has scheduled a field hearing in Denver, CO on draft legislation *"to reauthorize the Indian Health Care Improvement Act of 1976, as amended"* for Monday Dec. 6, 1999. An Osage Tribal representative will not be able to attend the hearing. However, we offer this letter as support for a proposed amendment to the IHCIA.

The Osage Tribe is administering a Tribal TANF Program under terms in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. We have discussed the possibility of the Tribe administering a Food Stamp Program and determining Medicaid eligibility.

Tribal one-stop services will ease the stress on clients regarding transportation (a major barrier to delivery of services) and redundant and laborious program applications that need to be completed for eligibility determination.

The Osage Tribal TANF Program supports the National Congress of American Indians, Resolution # GRB-98-046, *"Develop HHS and DOA, regulatory language to allow Tribal TANF Tribes to provide one stop shop for cash assistance, Food Stamps and Medicaid eligibility determination."*

It has been brought to our attention that the language, *TANF Tribes are authorized to determine eligibility for Federal Medicaid,* was deleted from the proposed bill for the reauthorization of the Indian Health Care Improvement Act (IHCIA) of 1976. By deleting the proposed amendment language from the reauthorization bill, TANF Tribes would be unable to evolve, as the States have evolved, and provide one stop programs that will ease the stress for Native American clients. The State of Oklahoma's assistance programs has been evolving for decades and have Federal statutory and regulatory relief for program development.

Therefore, we support the proposed amendment to the Indian Health Care Improvement Act that will authorize Tribal TANF Programs to determine eligibility for the Federal Medicaid Program.

Sincerely,

Raymond Lasley, Director
Orage Tribal TANF Program

cc: Virginia Hill, Director Social Services, Southern Indian Health Council
Sarah Hicks, Welfare Reform Program Manager, NCAI

TESTIMONY OF JACOB ADAMS
PRESIDENT, ARCTIC SLOPE REGIONAL CORPORATION

REGARDING
S. 2526, A BILL TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND SUCH ACT

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS

HEARING HELD JULY 26, 2000

Mr. Chairman and Members of the Senate Committee on Indian Affairs, my name is Jacob Adams and I am the President of Arctic Slope Regional Corporation (ASRC), an Alaska Native Corporation created under the Alaska Native Claims Settlement Act (ANCSA) and headquartered in Barrow, Alaska. ASRC has over 7,500 Alaska Native Shareholders and represents the interests of all of the North Slope Inupiat Eskimo people in the northern most region of Alaska. I appreciate this opportunity to provide testimony to you on behalf of ASRC regarding Title IV of S. 2526.

I am submitting written testimony to demonstrate ASRC's support for Title IV, Section 406(g), of S. 2526. This important Section of S. 2526 amends Section 1621e(f) of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1621e(f) (2000)). This amendment clarifies that neither the United States, acting through the Indian Health Service (IHS), nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, shall have a right of recovery for reasonable charges billed or expenses incurred in providing health services 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, or urban Indian organization. Section 406(g), however, does allow such recovery where there is specific written authorization by the governing body of an Indian tribe.

The Current Provisions of the IHCIA

The IHCIA, as currently written in the United States Code, has been interpreted to negatively impact those Indian tribes or tribal organizations that provide health care coverage to employees through a self-insurance plan. The IHCIA defines the term "Indian tribe" to include Alaska Native Corporations, such as ASRC, created pursuant to ANCSA. See 25 U.S.C. § 1603(d) (2000). ASRC currently has a self-insurance plan, which fits within the IHCIA's definition of a "self-insurance plan funded by an Indian tribe or tribal organization."

The IHCIA was enacted in 1976. See Pub. L. No. 94-437, 90 Stat. 1400 (1976). In 1988, Congress added a provision to the IHCIA, allowing the Federal government to recover from third-party payors reasonable expenses incurred by the IHS in providing health care services. See 25 U.S.C. § 1621e(a) (2000). In 1992, Congress broadened that recovery provision to allow the same type of recovery by tribes and tribal organizations contracting with IHS to provide health care services. Also in 1992, Congress added an exception to this right of recovery whereby, "[t]he *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." 25 U.S.C. § 1621e(f) (emphasis added).

There is a lack of parity between the right of recovery provision under 25 U.S.C. section 1621e(a), which is available to the "United States, an Indian tribe, or a tribal organization", and the exemption on recovery under 25 U.S.C. section 1621e(f), which is available only in cases where the "United States" is seeking recovery. Thus, as currently written, the IHCIA has been interpreted to provide that a self-insurance plan funded by an Indian tribe can only avoid being recovered against when the health care provider is the United States, acting through IHS, and not when the provider is a tribe or tribal organization contracting with IHS. The result is that Indian tribes are essentially being billed for health care provided to tribal members who are entitled to free health care services from the IHS and from tribes and tribal organizations contracting with IHS. This was not Congress' intent when enacting the IHCIA.

The foregoing result is the unfortunate situation that ASRC has been faced with. ASRC's self-funded insurance plan is being billed by a tribal health organization that has a contract to provide IHS services to American Indians and Alaska Natives. Whereas, if the IHS were providing the health services directly, ASRC's self-funded insurance plan would be exempted from such recovery. This result is not compatible with Congress' intent to provide health care services to American Indians and Alaska Natives, at the Federal government's expense.

In a House Report accompanying the 1621e(f) exception, the Committee stated that it "does not intend 25 U.S.C. Section 1621e to be interpreted to authorize the [IHS] to seek reimbursement from tribally operated self-insurance plans." H. Rep. No. 102-643(I), 102d Cong., 2d Sess., *reprinted in* 1992 WL 163494, *192-93. The Committee

went on to state that "[t]his would result in shifting the legal obligation to pay for Indian Health Services for tribal members to the tribes themselves." This rationale for exempting tribally funded self-insurance plans from the collection efforts of the IHS should equally apply to the collection efforts of Indian tribes and tribal organizations contracting to provide IHS services.

The Recovery Provisions as Clarified by S. 2526

As stated above, the IHCIA defines the term "Indian tribe" to include Alaska Native Corporations created pursuant to ANCSA. Section 406(g) of S. 2526 would limit the ability of the IHS, or a tribe or tribal organization, to recover from a self-insurance plan funded by an Indian tribe, including an ANCSA Corporation. As a result, under Section 406(g) of S. 2526, neither the IHS, nor a tribe or tribal organization contracting to provide health care to American Indians and Alaska Natives, shall have a right of recovery under the self-insurance plan funded by ASRC, without specific written authorization of the governing body of ASRC.

This clarifying provision in S. 2526 would further the Federal policy of providing health care to American Indians and Alaska Natives at the expense of the Federal government, but not at the expense of tribal members or Indian tribes. This provision would clarify that such Federal responsibility for health care was not intended to be borne by an Indian tribe, including an ANCSA Native Corporation such as ASRC.

On behalf of the 7,500 Inupiat Eskimos represented by ASRC, I would like to thank the Committee for allowing me to submit my testimony, for the record, in support of Section 406(g) of S. 2526.

NATIONAL

INDIAN

CHILD

WELFARE

ASSOCIATION

President
Gary Peterson
Skokomish

Vice President
Eloise King
Wenatchee

Secretary
James Knapp
Seneca

Treasurer
Dan Gargan
Rosebud Sioux

Board Members:

William Clark
Cherokee

Donna Fleagle
Athabaskan

Debra Foxcroft
Tsesholt

Delores Greyeyes
Navajo

Judy Houck
Coeur d'Alene

Tracy King
Assiniboine

Gabriel Landry
Puyallup

Robert Lewis
Pima/Maricopa

A. v. Martinez, Ph.D.
Chumash

Robert Miller
Eastern Shawnee

Don Milligan
Cree/Assiniboine

Elizabeth Red Bear
Yakama/Nez Perce

Muriel Sharlow
Ojibway

Lois Sohappy
Warm Springs

Ernie Stevens, Jr.
Oneida

Mary Tenorio, Ph.D.
Santa Domingo

Rick Thomas
Santee Sioux

Gil Vigil
Tesuque

Canadian Alternate
Gloria Wilson
Squamish

Executive Director
Terry L. Cross
Seneca Nation

STATEMENT OF THE

NATIONAL INDIAN CHILD WELFARE ASSOCIATION

SUBMITTED TO THE SENATE COMMITTEE ON INDIAN AFFAIRS

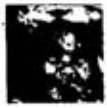
REGARDING S. 2526

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

JULY 26, 2000

Terry L. Cross
Executive Director

3611 SW Hood Street, Suite 201, Portland, OR 97201
Phone: 503.222.4044 Fax: 503.222.4007
e-mail: info@nicws.org website: www.nicws.org



The National Indian Child Welfare Association appreciates the opportunity to submit this testimony on. S. 2526, a bill to amend the Indian Health Care Improvement Act (herein referred to as "The Act"). Our organization is based in Portland, Oregon. Our comments will focus on the following themes as they pertain to S.2526:

1. *Systems of Care and its relationship to behavioral health services and our recommendation that S. 2526 include this concept;*

2. *The serious need for increased funding to expand services and provide better access to mental health care for American Indian/Alaska Native children;*

3. *The need for Indian Health Service (IHS) to acquire and provide specific data related to Indian children's mental health.*

Our recommended changes to S.2526 begin on page 9 of our testimony.

The National Indian Child Welfare Association (NICWA): NICWA provides a broad range of services to tribes, Indian organizations, state and federal agencies and private human service agencies throughout the United States. These services are not direct client services such as counseling or case management. They are services that strengthen the programs that directly serve Indian children and families. NICWA services include: (1) professional training for tribal and urban Indian human services and mental health professionals; (2) consultation on human services and mental health program development; (3) facilitating child abuse prevention efforts in tribal communities; (4) analysis and dissemination of public policy information that impacts Indian children and families; (5) training institutes on Indian children's mental health topics; and (6) helping state, federal and private agencies improve the effectiveness of their services to Indian people. In addition to maintaining a strong network in Indian country by working closely with the National Congress of American Indians and tribal governments across the United States, we have established mutually beneficial partnerships with child and family welfare organizations such as the Federation of Families for Children's Mental Health, the Child Welfare League of America, and Casey Family Programs.

SYSTEMS OF CARE AS THE CORNERSTONE OF BEHAVIORAL HEALTH
What is a system of care? Within the field of children's mental health, a system of care is a formal collaboration of the family and community members, professional and other organizations committed to enhancing the lives of emotionally disturbed children and their families. The purpose is to bring cohesion to the strategies and services aimed to rehabilitate these children. Specific values set the principles that drive a system of care. These principles evolve into specific practices that create change.

Systems of care has evolved over the past several years from the growing awareness of the absolute need for all stakeholders in children's well-being to work together. Service providers now recognize that simply dispensing medication and providing adjunctive

psychotherapy services fall short of what children and their families need to recover from or cope with mental illness. They recognize that the causes of mental health disorders are complex and that the impact of mental illness requires collaboration and partnerships among many parties.

Wraparound services comprise a full array of human services. *Case management, or care coordination*, connects all parties providing this full array of services into a collaborative web. Systems of care include formal partnerships between tribal, state or county agencies (*partnerships)*, multi-disciplinary teams (*collaboration)*, deep *family involvement* and the accessibility to service providers far beyond the typical 8 a.m. to 5 p.m. workday. Wraparound services include children and families in the planning of the treatment for the children. In addition to professionals, effective systems of care bring into this planning the significant persons involved in the child and his/her family's life, such as spiritual healers, extended family and community elders. Professionals may include educators, child protection services, the juvenile justice system and mental health professionals (Cross, Earle, Echo-Hawk Solie and Manness, 2000).

S.2526 combines the fields of substance abuse and mental health into a behavioral health department and emphasizes traditional healing as an important part of wellness. We agree with this approach, but the bill does not, unfortunately, encourage systems of care. This omission is inconsistent with other HHS agency policy and today's most promising practices.

Throughout the past decade, the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration, has emphasized the importance of systems of care in meeting the complex needs of children suffering from mental illness and their families. Within Indian country, during the past seven years, CMHS has funded a total of 8 tribal mental health programs that provide services to Indian children with severe mental health challenges. These programs are excellent examples of tribes and tribal organizations developing creative, effective mental health systems of care. We are attaching to this testimony a copy of the *Promising Practices: Cultural Strengths and Challenges in Implementing A System of Care Model in American Indian Communities* (Cross et al., 2000). This monograph describes 5 of the 8 programs. Following are excerpts from this monograph that describe the extent of collaboration inherent in systems of care. In this case the description is of the Sacred Child Project, which is coordinated by United Tribes Technical College and serves 5 sites in North Dakota, South Dakota and Montana.

> "*Sacred Child* staff and spiritual consultants have an unconditional love for the children and their families who participate in the project."
>
> "Participants are visited by a care coordinator and, if available, a parent coordinator…, they understand the community dynamics and culture and they are aware of the services and programs in the community …. [they must] be willing to train to become certified in care coordination."

"Their [the child and his/her family] application is then forwarded to the local Wraparound Review Intake Team (WRIT), a multidiscipline team composed of parents, care coordinators and representatives from cultural, spiritual, child welfare, mental health, law enforcement, juvenile justice, education, alcohol and substance abuse prevention and domestic violence areas."

"The next step in the wraparound process is to set up a meeting of the child and family support team. At this meeting, the parents or primary caregivers and the child, if age appropriate, meet other members of the child and family support team (CFST). This team is comprised of people the family has identified as being part of their natural support system and the service providers from the systems with which the child is involved."

"The purpose of the support team meeting is to develop a plan of care appropriate for the family's strengths and culture."

From the above example, one can see the high degree of involvement of Sacred Child Project staff with families and community members, and how a system of intervention extends beyond providers to community members that are known to the family. When a family and community are brought into a system that works together to promote healing, the motivation to succeed exceeds discrete efforts by one individual or one agency acting independently. With the work spread throughout formal and informal entities, a system can be available 24 hours/day to stabilize families. Different players are called into action based upon the need at any given time. For example, a mental health specialist, traditional or mainstream, may be called to respond to a suicidal teen; or a protective services worker may put a remedial care plan into immediate action to prevent child abuse and the removal of a child into foster care.

According to parents and staff interviewed for this monograph, this level of involvement has resulted in saving lives of suicidal adolescents, reducing school absenteeism and expulsion, improving school grades, decreasing the rate of recidivism into the juvenile criminal justice system, increasing self esteem, preventing child abuse, and keeping children within their homes as opposed to placing them into foster care or residential treatment. These changes transform the lives of children and families. One can speculate that the cost savings would be enormous by providing extensive services at the front end versus the exorbitant costs of "back end" services such as incarceration, protective placement and in-patient psychiatric hospitalization, as well as general assistance. Providing effective services to children will likely also save costs from social security disability benefits, since chronic, severe mental illness often renders people unemployable.

CMHS recognizes that many Indian communities have gone too long without mental health services and that these communities lack the infrastructure to support an effective mental health system. In its commitment to bridging the gap in services to Indian children, CMHS funded nine tribal and urban Indian programs whose mission is to design systems of care. These projects, called Circles of Care, are in addition to the 8 sites

mentioned above providing services. They have been given three years to establish partnerships and to involve the community in designing a system of mental health services for their children. IHS is aware of this emphasis in mental health policy and is, in fact, one of the partners in these CMHS funded grants.

INDICATORS OF NEED FOR IMPROVED MENTAL HEALTH SERVICES TO CHILDREN IN INDIAN COUNTRY

In general, mental health services are scarce for all children. But for Indian children, access is more problematic. The disparity in available resources parallels the scarcity of data relevant to Indian children and mental health.

Available Statistics: Severe life stresses place Indian children at high risk for mental health problems. On a national level Indian communities are affected by very high levels of poverty, unemployment, accidental death, domestic violence, substance abuse, child neglect and abuse, and suicide. These at-risk factors lead most authorities to agree that there is an inordinate, unmet need for mental health services in tribal communities (Swinomish Tribal Mental Health Project, 1991).

There is very little data on the mental health needs of Indian children and adolescents (Deserly and Cross, 1996; U.S. Congress, Office of Technology Assessment, 1990). We can make some extrapolations about the level of need for Indian children and the importance of addressing those needs from statistics pertinent to the general population, particularly since we know that minorities with mental health disorders are less likely to receive treatment and more likely to be placed in correctional facilities (Knitzer, 1982). We know the following to be true:

1. Mental disorders account for 4 of the 10 leading disabilities in established market economies worldwide (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

2. The cost of mental illness in the United States was $148 million in 1990 (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

3. Worldwide, depression is the leading cause of disabilities among persons *age five* and older (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

4. The estimated national incidence of emotional disturbance is 11.8 percent of the population under the age of 18 (Gould, Wunsch-Hitzig and Dohrenwend, 1980).

We can see that the cost of mental illness is extraordinary. In Indian country where mental health services are extremely scarce and the need is disparately great, we can assume that both the life-long personal and financial costs of not providing adequate mental health services to our children will be enormous.

The 1990 Census reports that almost two million American Indian people are living in the United States. Of this number, 39 percent are under the age of twenty. Research estimates that there are approximately 93,000 emotionally handicapped Indian children in the United States (Deserly and Cross, 1996).

Although epidemiological research is scarce, we know that Indian children suffer from catastrophic rates of posttraumatic stress, which, if untreated, creates a generation of adults who suffer from severe, chronic mental illness. Boarding school surveys have identified Indian youth as being at high risk for mental health disorders. According to an unpublished paper by the Bureau of Indian Affairs (1995), *Therapeutic Residential Schools – Promise of the Future*, off-reservation, residential school students are either "at risk" or are "very high risk" students. Most of these students have suffered sexual, physical and emotional abuse, abandonment and/or rejection and have been involved in self-destructive behaviors. Supporting documentation shows that many students with mental health problems are on probation from the juvenile court system. In addition, the scope of alcohol and drug abuse among entering students is overwhelming: 80 percent to 100 percent! Over 80 percent are from home environments where one or both parents have been identified as having a substance abuse problem. The paper further reports increasing dysfunction in all areas investigated in mental health screenings. The majority of students screened (approximately 95 percent) reported critical medical, social, mental and educational needs that are not being met.

Historical Factors. The effects of past forced removal of Indian children from their native societies and placement into boarding schools, adoptive and foster homes are only now being fully recognized. Children changed in ways that their parents and grandparents could not understand. Many returned home for vacations expressing serious identity confusion. They grew ashamed of being Indian and bitterly disowned the values and lifestyle of their families. After years in boarding schools, they grew up unable to fit comfortably into either Indian or non-Indian societies (Swinomish Tribal Mental Health Project, 1991). Many times, these children never returned to their homes. For those who did, communication was damaged because children had been forbidden to speak their native languages. Many children were unable to converse with their own parents. Having been denied normal Indian childhood experiences and role models, they were delayed in their social and emotional development (Attneave, 1977).

As these children became parents, they met unprecedented challenges. They lacked family experience from which to learn parenting skills. They struggled with major depression and attachment disorders resulting from their trauma of forced separation. Generations of Indian parents resorted to substance abuse, neglected their children and found themselves overwhelmed by the challenges of parenting (Hollow, 1982). This yielded an upsurge in child neglect and abuse resulting in the removal of successive generations of Indian children from their parents. Thus the history of removal of Indian children from their families created a cycle of multi-generational trauma that continues to cause emotional illness in today's generation of Indian children.

Without a commitment on the part of IHS to mental health systems of care, the outlook for Indian children is dismal. Given the knowledge we now have about the positive outcomes of systems of care established within Indian communities, it makes good sense for IHS to make such a commitment. Should IHS do so, the outlook is optimistic. There are three reasons for the optimism. One is that IHS is beginning to develop some expertise in systems of care via their collaboration with the CMHS grants. The second is that today's research is clarifying the neurobiological processes involved in trauma, and this research points to promising remedies. The third reason is that Indian communities have demonstrated their competence in and desire to develop systems of care.

Lack of Access and Specific Services Needed: Today's research reports that there is a narrow window of opportunity (six months) for treating victims of trauma before they suffer from neurological damage (Perry, in press; Perry and Marcellus, 1977). Untreated, repetitive trauma can result in learning deficits, posttraumatic stress disorder and a myriad of mental health symptoms that seriously interfere with a person's ability to cope with life. These symptoms generally continue throughout adulthood (Perry, in press; Perry and Marcellus, 1977). The repercussions of persistent trauma contribute to the high rate of Indian youth dropping out of school, entering the juvenile justice system and abusing alcohol and drugs. They also contribute to the high teenage pregnancy rates and high rates of babies affected by fetal alcohol and drug abuse.

Today's research documents the results of separation of children from their parents. Attachment disorders reflect the neurobiological impact of this trauma. Research also shows the correlation between mental health disorders and high rates of diabetes, cardiac and other diseases (Koren, DeChillo and Friesen, 1992; National Institute of Mental Health, *Science on our Minds: The Numbers Count*, 1999; National Institute of Mental Health, *Science on our Minds: Depression Can Break Your Heart,* 1999). Given that American Indians have the highest rate of diabetes, obesity and heart illnesses, there is a great need for mental health services as prophylactic, medical health measures. Additionaly, one can extrapolate, from the research on the neurological impact of trauma, that mentally ill children, left untreated, are at high risk for serious health problems as adults.

There are several reasons for disparity of mental health services to Indian children.

Low IHS Funding. Historically, mental health, particularly mental health services for children, has been low on the IHS list of funding priorities. In 1988, only 1.3 percent of the total budget was allocated for mental health and social services for all age groups (U.S. Congress, Office of Technology Assessment, 1990). Today, IHS allocates approximately 3 percent of its budget for mental health and social services combined with no set policy for allocation to children's services. These funding decisions have resulted in severe shortages in mental health, which is exacerbated by the fact that 90 percent to 95 percent of psychiatrists and psychologists work in metropolitan areas. (Wagenfeld, Murray, Mohatt and DeBruyn, 1994). There is a critical need for pediatric neuropsychiatrists who specialize in fetal drug and alcohol disorders. Shortages of this

nature result in poor assessment of need, inadequate crisis intervention and misdiagnosis. These are potentially life threatening.

Jurisdictional Confusion. Confusion between agencies regarding who has the responsibility of serving Indian children often leads to no services. Federal, tribal, state and local governments all bear some degree of responsibility for the mental health of all children. Their perception that 'the other agency is responsible' has resulted in virtually no coordination of services, let alone the development of a formalized system" (Cross et al., 2000).

Geography. Another reason for disparate mental health services is geography. Great distances, sometimes hundreds of miles, prevent access. In Alaska, many villages can be reached only by air in winter and in the summer months some villages are also accessible by boat. Many tribal programs have very large service areas. Clients may have to travel hundreds of miles for an appointment; children may placed in homes or treatment centers far from heir home communities, thus making it very difficult for family visits. If services are home-based, only a few clients a day can be seen because of the enormous distances a worker has to travel.

Cultural Obstacles. Although state and county mental health programs which are federally funded are theoretically available to all residents, mental health agencies generally have been unsuccessful in serving Indian people. For the most part, services offered by state and county agencies are culturally inappropriate for Indian clients, many of whom feel uncomfortable dealing with non-tribal agencies. When mental health providers are unfamiliar with tribal lifestyles, family values or communication style, there is a high probability of misunderstanding. Many non-Indian providers are not even aware that important value differences exist. This lack of awareness increases the danger of Indian clients being misunderstood, labeled or rejected (Swinomish Tribal Mental Health Project, 1991). Misdiagnosis of Indian clients can result in serious medical and emotional damage. Cultural norms, such as spiritual visions, are sometimes misinterpreted as psychoses, for example, and treated with medication when no medication is necessary.

Inadequate Diagnostic Services. Because of the lack of resources, Indian communities have dangerously poor access to psychiatric services and the latest neuropsychiatric information and technology that is prerequisite to accurate diagnosis. Inaccurate diagnosis can result in inappropriate prescribing of medication and ineffective treatment plans, as well as impacting school decisions for special education assessment and placement, accepting children into regional centers that guarantee life-long care, denial of social security disability benefits, etc.

There is great complexity in diagnosis. This complexity is further compounded by an increase in children struggling with multiple mental health disabilities, including those related to fetal drug and alcohol abuse. The field of pediatric neuropsychiatry is important in accurate diagnosis. Accurate diagnosis is prerequisite to developing appropriate treatment plans and for prescribing medication. Assessment is an evaluation

of the various symptoms; diagnosis is the determination of the illness. Although assessment leads to a diagnosis, without an accurate diagnosis, service providers cannot develop an effective treatment plan.

Hazards of Misdiagnosis: The following example illustrates the life threatening consequences of inadequate diagnosis.

One psychiatric social worker reports spending over 200 man hours identifying a psychiatrist with sufficient expertise to diagnose and prescribe treatment to a 9-year-old Indian youth who had been grossly effected by fetal alcohol and drug abuse, including methamphetamine, cocaine, LSD, marijuana and hashish. A pediatrician treated this child for attention deficit disorder; however, he failed to diagnosis the other psychiatric disorders of the child. The treatment prescribed, therefore, was inappropriate. Additionally, the county mental health system said the child did not have a mental health disorder and denied the child access to the day treatment program and services. The school special education program was ineffective in dealing with the severe behavioral problems resulting from the mental illness. After months of exploration, the Indian behavioral health program located a psychiatrist who recognized that the child was schizophrenic in addition to suffering from attention deficit disorder, pervasive developmental disorder and fetal drug and alcohol effects. For the first time, the child's psychotic symptoms were identified and then addressed. Because of long-term, high dosages of Ritalin, the child developed an irreversible cardiac problem. Had this child had access to a neuropsychiatrist trained to work with children, successful diagnosis and resulting treatment would have been implemented several years prior, and the cardiac problems would likely have been avoided. More alarming is that many tribal programs have no mental health professionals who would recognize the need for specialized assessment and diagnosis. Children receiving services in these programs are at high risk for misdiagnosis and ineffective treatment.

Benefits of Accurate Diagnosis: Within a year after the above-discussed child entered into treatment with an appropriately trained psychiatrist, he entered the County mental health's day treatment program. He was accepted into the state's regional center. His psychotic symptoms abated. His family received home-based behavioral management services as well. This child will never function "normally," but there is a life-long care plan set up for him which will be revisited on a regular basis and modified according to need.

IMPORTANCE OF DATA.

There are no hard figures on how many dollars IHS allocates to children's mental health. There is a lack of IHS data documenting the extent and the severity of these children's mental illnesses. State and county agencies often lump American Indian/Alaska Native into the "all other" category, so their statistics omit data on American Indian children. To make matters worse, state and county workers frequently identify Indians as Hispanic because of Spanish surnames. The undercount of Indian children struggling with mental illnesses undermines efforts to address these problems.

While IHS has a mental health/social services data collection system, there are many problems inherent in the system. Not all behavioral health programs use the system. It competes for statistics with a chemical dependency data collection system, and workers do not want to input data for two separate systems. The forced choices of the program create confusion on how to respond to the specific data fields and important information is only intermittently reported. Finally, what data is collected is not disseminated.

The data collected by IHS is so problematic that it makes it difficult for us to present a recommendation that pertains to dollar allocations. The lack of reliable data allows state and county agencies to avoid developing culturally specific programs for Indian children, as well as impeding Indian tribes and urban organizations from successfully competing for grants.

RECOMMENDATIONS
(changes in language are printed in **bold**)

Issue Number One: The Act fails to address today's most promising mental health practice – systems of care for children's mental health.

Recommendation: Make the following changes in language:

- Sec. 701(a)(1) – add the following language at the end of the paragraph: **and which promotes the development of systems of care;**
- Sec. 701(a)(2) – insert the following language after the phrases: develop tribal plans **promoting systems of care** …organizations to develop **local systems of care** plans…
- Sec. 701(b)(1) – add paragraph **"(D) a design for a system of care rooted in wraparound service.**
- Sec. 701(d)(1) – add at the end of the paragraph **within a coordinated system of care.**
- Sec. 703(a)(1) –insert the following language after the phrase: … program of comprehensive behavioral health **systems of care addressing**
- Sec. 707(c)(2) – add paragraph **"(F) to develop collaborative systems of care.**
- Sec. 910(b)(6) – insert the following language after the phrase: … avoids duplication of existing services, **and facilitates the** development **of a system of care.** "

Justification: Systems of care is consistent with federal policy for mental health services to children and families. It involves the family and natural, indigenous systems of care that facilitate the empowerment of children and families, as well as expanding resources. It helps avoid duplication of services and contributes toward sustainability of behavioral

health services within an economy of dwindling resources. Systems of Care reduce costs by lowering the numbers of children placed out of the home (juvenile detention, foster care, residential treatment). They promote great success in prevention and treatment of mental health disorders by engaging the community in developing prevention and treatment strategies. The community becomes part of the treatment plan, thereby increasing the number of people supporting the child and the family in need.

Issue Number Two: The technical assistance language in S. 2526 is general and does not specifically address systems of care as a promising practice.

Recommendation: (insert the following changes in language.)

- Sec. 709(a)(2) – insert the following language after the phrase: concerning behavioral health **systems of care** ...
- Sec. 709(b) – insert the following language after the words: behavioral health issues, including **systems of care** ...

Justification: Indian communities need the benefits of state of the art information regarding current mental health services. Behavioral health program personnel should have access to the technical assistance that would assist them in developing mental health systems of care within their communities. In order to garner support for systems of care, tribal council members, other leaders and community members need training and education in this area. IHS staff could benefit from this such training for the same reasons. An additional benefit would be that an increased awareness would encourage collaboration between behavioral health services delivered directly by IHS to tribal communities and tribally run services.

Issue Number Three: There is a severe lack of mental health personnel trained to work with children.

Recommendation: Amend Sec. 127(1) as follows: change the number 500 to **1,000.**

Justification: S.2526 moves toward addressing the mental health needs of Indian children by acknowledging the critical lack of mental health practitioners working in American Indian/Alaska Native programs, particularly those specializing in working with children and families. The Act calls for the recruitment of 500 mental health providers with a minimum of 200 qualified to work with children. Given the extraordinary unmet need for mental health services for Indian children, 500 new practitioners is grossly inadequate. This is particularly true when we are recruiting practitioners whose expertise ranges from professional to paraprofessional and when you consider that rural case loads are smaller than urban case loads due to time spent on travel. Furthermore, the figure of 93,000 Indian children needing mental health services is a conservative estimate. There is no indication of a decrease in the ratio of one mental health provider to every 23,250 children. We believe that recruiting 1,000 new mental health practitioners is a reasonable goal over the next several years.

Issue Number Four: The Act calls for two fifths of the recommended new mental health personnel to have training in the field of children's mental health; specifically, 200 of 500. This is inadequate in meeting the unmet needs of Indian children and creates a bigger gap in available services between adults and children.

Recommendation: Amend Sec. 127(1) as follows: change the number 200 to **600**.

Justification: We are recommending that instead of two fifths of new hires having expertise in working with children that three fifth have such expertise. There is already a preponderance of providers working with adults. This disparity in distribution of human resources is higher when one considers that mental health providers working with children and families spend much of their time working with adults. The greater need is to bridge the gap in availability of services for children.

Issue Number Five: Access to psychiatric services is severely limited. This is particularly true for children with multiple diagnoses. This lack of access is further damaging to children suffering from neurological impairments, such as those associated with fetal drug and alcohol disorders.

Recommendation:

- Sec. 701(c)(1) – Add paragraph **"(J) diagnostic services including the utilization of the latest neurological assessment technology**
-
- Sec. 703(a) – Add paragraph **"(F) diagnostic services utilizing, when appropriate, neuropsychiatric assessments that use the latest technology of PET (photon emission topography) or SPECT (single photon emission computer topography) scans.**
-
- Sec. 703(a) – Add paragraph **"(G) develop and institute a telepsychiatry program drawing upon the experts in the field of pediatric psychiatry, including psychiatrists in assessment, diagnosis and treatment planning for children with concurrent neurological disorders.**

Justification: Indian communities generally have poor and frequently no access to psychiatrists. Access to neuropsychiatrists is even more limited, and access to pediatric neuropsychiatrists is extremely rare. In S.2526, Title VII, Behavioral Health, The Act does not directly address the area of diagnosis, although it does address assessment. It is unrealistic to expect every Indian behavioral health program to have an on-site psychiatrist. With 1,680 U.S. counties lacking these services, many Indian children must have alternatives. A telepsychiatry program would make psychiatric services available to all Indian children. The use of PET or SPECT scans would ensure the high quality of differential diagnosis (MRI's, CAT scans and Xrays show the physical structure of the

brain, while PET and SPECT scans show the ability of the brain to function by mapping activity levels,)

Issue Number Six: Data on Indian children's mental health is scarce and results in obstacles in justifying funding needs, understanding the extent of Indian children's mental health needs and, therefore, developing appropriate strategies.

Recommendation:

- IHS create a task force to assess the current mental health/social services data collection system. This task force would also explore how data from the separate IHS medical data system can contribute to developing an accurate picture of the mental health needs of children and families. The committee would be comprised of members from IHS, tribal leaders, mental health professionals from IHS and tribally run programs, as well as at least one representative from an urban mental health program and at least one representative from an appropriate Indian organization involved in research and/or data collection related to Indian children's mental health.

- All IHS funded programs use the mental health/social services data collection system or provide identified statistics, so that IHS can aggregate them into their data.

- Within the next 12 months IHS be required to produce a report to Congress on status of Indian children's mental health based on data collected per the recommendations of the task force (see first bullet of this set of recommendations) and that IHS disseminate this report to Indian tribes and appropriate organizations.

- Subsequent to the above report, IHS be required to produce a report on the status of Indian children's mental health on a biannual basis.

Justification: Not all IHS funded programs utilize the same data collection systems. Some behavioral health departments are burdened with two systems; one for mental health and social services; the other for substance abuse services. There is considerable confusion regarding how to use these systems when a child is dually diagnosed. In addition, the current mental health/social services data collection system being used by IHS collects information in such a way that obtaining other important information is excluded. Although information regarding age is collected, obtaining meaningful data from IHS does not appear possible. The loss of these data deprives Indian communities and grant writers of the information they need to understand the scope of mental health illness in Indian children. Many individuals who seek medical services are being treated for mental health problems, and services provided by medical health do not get processed into the mental health data collection system. The loss of data through services provided by the medical departments undermines the extent of the problem. This, in turn,

undermines the attempts to justify requests for grants and other funding. Tribes and tribal organizations do need those data that are collected.

CONCLUSIONS

The need for mental health systems of care for Indian children, although inadequately documented, is expected to be substantially higher than that of the general population. Access to services is poor for a variety of reasons including cultural issues, funding, isolation and the need for human resource development. We are recommending that 600 additional mental health practitioners be trained to work with children to address this unmet need.

It is critical that IHS mental health policy keep pace with that of the CMHS and that IHS promotes systems of care within the programs they directly operate, as well as provide technical assistance to tribes and urban organizations running their own behavioral health programs.

We urgently recommend that IHS implement a telepsychiatry program that ensures that Indian children have access to effective diagnostic services. These services must include evaluations from pediatric neuropsychiatrists who have expertise in fetal drug and alcohol disorders and who use PET and SPECT scans in their evaluation.

Data collection and analysis is vital to comprehending the extent of the mental health needs of Indian children, as well as to justify requests for funding and developing intervention strategies. Indian communities have long been hampered by the lack of supporting statistics in their attempts to pursue funding. A task force is recommended to develop an effective data collection system, and a compulsory report would ensure that IHS would acquire and disseminate appropriate data. Follow-up biannual reports would continue to inform Congress and Indian constituents on the status of mental health of Indian children.

The Act carries recommendations through the next decade. The complexity of mental health disorders and solutions to these diseases are just now beginning to be appreciated on a large scale. This Committee has the opportunity to adopt recommendations that would pave the way for substantial cost savings. This Committee also has the opportunity to make a strong statement not only on your commitment to the well being of Indian children but also on your commitment to innovative, effective solutions based in collaboration, partnerships and community ownership of solutions.

Thank you for your attention to this request.

BIBLIOGRAPHY

Attneave, C., 1977. "The Wasted Strengths of Indian Families" in Steven Unger (ed.), *The Destruction of American Indian Families*. New York, NY: Association on American Indian Affairs.

Bureau of Indian Affairs, unpublished. "Therapeutic Residential Schools—Promise of the Future." Washington, DC, Office of Indian Education, distributed at August 1995 Indian Mental Health Advisory meeting, Washington, DC.

Cross, T., Earle, K., Echo-Hawk Solie, H., & Manness, K., (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health, 2000 Series, Volume I.* Washington, DC: Center for Effective Collaboration and Practices, American Institutes for Research.

Deserly, K.J., & Cross, T.L. (1996). *American Indian children's mental health services: An assessment of tribal access to children's mental health funding.* Portland, OR: National Indian Child Welfare Association.

Geboe, Charles, 1995. Bureau of Indian Affairs, Report to the Indian Children's Mental Health Initiative Meeting, October.

Gould, M., Wunsch-Hitzig, R., and Dohrenwend, B.P., 1980. Formation of hypotheses about the prevalence, treatment and prognostic significance of psychiatric disorders in children in the United States. In Dohrenwend, B.P., Dohrenwend, B.S., Gould, M.S., Link, B., Neugecauer, R., and Wunsch-Hitzig, R., Eds., *Mental Illness in the United States.* New York, NY: Praeger Press, 9-44.

Hollow, Walt, 1982. "Health and Mental Health." In *Indian and Alaska Native Mental Health Seminars*, Seattle Indian Health Board, p. 263.

Knitzer, J. 1982. *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services.* Washington, DC: Children's Defense Fund, p. 6.

Koren, P.E., DeChillo, N., & Friesen, B. 1992. Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. Rehabilitation Psychology, 37 (4), 305-321.

National Institute of Mental Health. 1999: *Science on our Minds: Depression Can Break Your Heart.*

National Institute of Mental Health. 1999: *Science on our Minds: Seeing our Feelings.*

National Institute of Mental Health. 1999: *Science on our Minds: The Numbers Count.*

Perry, Bruce D. Memories of Fear: How the brain stores and retrieves physiologic states, feelings, behaviors and thoughts from traumatic events. (in press)

Perry, Bruce. D. and Marcellus, J. 1977. *The impact of abuse and neglect on the developing brain in* Colleagues for Children, Missouri Chapter of the National Committee to Prevent Child Abuse.

Swinomish Tribal Mental Health Project, 1991. *A Gathering of Wisdoms, Tribal Mental Health: A Cultural Perspective*. Mt. Vernon, Washington: Veda Vanguard.

U.S. Congress, Office of Technology Assessment, 1990. *Indian Adolescent Mental Health,* OTA-H-446 Washington, DC: U.S. Government Printing Office, January.

U.S. Congress, Senate Committee on Labor and Public Welfare, Special Committee on Indian Education, Indian Education, 1969. *A National Tragedy—A National Challenge*, Report 91-501. Washington, DC: U.S. Government Printing Office.

Wagenfeld, Murray, Mohatt and DeBruyn, 1994. *Mental Health in Rural America,* Washington, DC: U.S. Government Printing Office.

TESTIMONY FOR THE RECORD
OF CHAIRMAN WAYNE TAYLOR, JR.
SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON S. 2526, TO REAUTHORIZE THE INDIAN
HEALTH CARE IMPROVEMENT ACT
JULY 26, 2000

Thank you, Chairman Campbell, Vice Chairman Inouye, and other distinguished Members of the Senate Committee on Indian Affairs for allowing the Hopi Tribe to provide testimony on S. 2526, legislation to reauthorize the Indian Health Care Improvement Act. We are grateful for your continued attention to improving health care services for all Native Americans.

The Hopi Tribe looks to Congress as the ultimate federal trust authority. Vested in your authority is the ability to ensure the provision of quality health services for all Native Americans. We value your counsel and depend in no small measure on your assistance in establishing an array of health services of critical importance to all Tribes.

I wish to draw your attention to one health care service that has been largely ignored to date in Indian country – the provision of emergency medical transportation services.

Paramedics and Emergency Medical Technicians (EMTs) who provide emergency medical care and transportation to the general population were recognized as an important part of the health delivery system in 1966, with enactment of the Highway Safety Act. The Act provided funding to States to buy ambulances and train EMT-paramedics. States required those involved in the transport of sick or injured people to be certified as emergency medical technicians. Since the mid-1960s, this field has exploded and evolved with medical technology to provide essential front-line medical services as part of the continuum of care. Unfortunately, this critical component in today's health care system is underfunded in Indian country. Tribes are unable to keep pace with health care advances in this field. A growing disparity between comparable care off-reservation is evident and access to health services is impeded.

On the Hopi reservation, providing necessary emergency medical transportation services is a difficult task. Insufficient funding for adequate staffing and outdated equipment leaves our present emergency medical service (EMS) team constantly struggling to provide services. Although the Hopi EMS team performs valiantly, its personnel are stressed for time and lack the equipment necessary to perform certain lifesaving functions. The program lacks the resources to staff the program according to industry standards for the time and distances involved in rural transport.

Unfortunately, the Hopi Tribe witnessed the consequence of insufficient program funding this past April through a tragic incident. A young woman developed a serious condition during her pregnancy. After being brought to the Keams Canyon Hospital for care, physicians determined that she would have to be transported to the Tuba City Indian Hospital (some 84 miles west), a facility more equipped to handle this condition and able to perform surgery not possible at Keams Canyon. As the young woman was being stabilized and readied for transport, another urgent call was received and the ambulance was obligated to transport that patient from the Second Mesa Clinic to the Tuba City Indian Hospital. A second ambulance crew was already attending a local emergency and was committed to remain on the Hopi Reservation. EMS funding is not sufficient to provide for a third "off-duty" or back-up EMS crew -- as industry standards dictate. As a result, the woman was forced to wait for the first available transport – an air ambulance -- several hours later. During this delay, the woman suffered fetal demise (the death of her unborn child) and her own life was placed in extreme jeopardy. This scenario, as well as many others, could possibly have been avoided by providing adequate funding for full staffing of the EMS program, affording a third crew "on duty" or as an "on call" back-up crew.

The current trend of closing hospitals in Indian country and replacing them with ambulatory care centers, or consolidating medical services, places an added burden on emergency medical services teams and elevates the importance of their role in providing necessary transport. With the rural nature of Indian Reservations, miles away from towns and urban centers, transportation is now needed over longer distances for inpatient care, requiring highly trained staff and more advanced equipment. Thus, the system itself is increasing the role of emergency transportation and advanced life support care without providing the necessary financial resources to meet the new need. The end result is a growing gap in the continuum of health care.

We urge the Committee to examine the importance of improving and providing adequate resources for emergency medical transportation services. We recommend that additional funding be provided for the development and maintenance of effective emergency transportation systems through a mechanism included in the reauthorization legislation. The Hopi Tribe views the development and maintenance of emergency medical care systems as part of the trust responsibility in providing essential health and welfare services.

Emergency Medical System Programs Are Important to Providing a Continuum of Health Care Services:

Emergency medical care has become an important part of our health care system, providing a front-line interface with the health care system. Medical ethics dictate certain models of practice to facilitate and insure competent patient care. Previously permitted practices, such as medically unsupervised patient transport or transport supervised by minimally trained individuals for patients with severe conditions, are no longer acceptable practice and are, in fact, illegal. Individuals trained in advanced cardiac care or advanced life support must accompany patients with head injuries, internal hemorrhages, high-risk pregnancies/labor, severe cardiac conditions,

or other life-threatening conditions when the patient is being transported.

Appropriate and expeditious emergency medical care not only means the difference between life and death, but can save substantial expense for the health care system. The health care community has learned in recent years that if appropriate care is administered to injured or sick individuals such as victims of heart attack within minutes of an event, loss of life can be prevented and the chance for full recovery is increased. The administration of expeditious care can save years of rehabilitative costs, lost labor, and other expenses. Injury is one of the leading causes of death among Native Americans. Emergency medical systems must be intact to respond to this public health need.

As the trend toward constructing more ambulatory short-term care centers continues, more hospitals will close. This trend will dictate an increase in emergency and inter-facility transports. It is the job of Congress to ensure the appropriate provision of health services to Native Americans and address this gap in coverage.

Emergency Medical Costs Have Increased Over the Past Two Decades:

Emergency medical costs have increased over the past two decades for the following reasons:

Industry Standards: Standards of care are developed by the industry to keep pace with advances in medicine. Courts often uphold standards of care as a measurement of liability. EMS standards define basic life support (BLS), advanced life support (ALS) and advanced cardiac life support (ACLS) modalities of care, ambulance configuration, dispatch and telecommunications protocol, resource distribution and interagency relations. As technology has improved our medical capacity to deliver state-of-the-art EMS care, standards of care have evolved to incorporate scientific advances in the practice of pre-hospital medical treatment.

Regulatory Bodies: EMS programs must meet many standards to operate as a legitimate health provider. To name a few, EMS programs must follow state and federal Department of Transportation guidelines, federal and state labor standards, federal Medicare standards, state certification and licensing, state or regional medical control/supervision, local permit/licensing, and standards for performance through written agreements.

Service Population Expectations: Americans expect access to high quality EMS services. The daily deluge of television programming demonstrates many of the state-of-the-art uses of emergency medical services. In rural areas where distances are great and the availability of transportation is a serious issue, a responsive and well-equipped EMS service becomes a lifeline upon which the community depends.

Cost of Technology: Technological developments in the delivery of health care services have increased dramatically in recent years. Equipment is highly sophisticated and improved, giving every advantage to saving a patient's life. A three-lead

monitor/defibrillator purchased in 1992 for $12,000 is now obsolete and subject to age-based failure. A twelve-lead monitor/defibrillator sold today can cost more than $20,000 and is essential for meeting "standard of care" treatment for pre-hospital medical care of the cardiac patient.

Cost of Readiness: Crews have to be ready to respond at all times of the day and night. Payment only occurs when actual transports to a medical facility are made. EMS calls that involve treatment rendered at the scene, with no transport, are usually not reimbursed. Similarly, in cases where EMS ground crews administer life saving care at the scene of an accident or other emergency, yet the patient is actually transported to the medical facility by air ambulance, no reimbursement is made.

The Hopi Tribe's Emergency Medical Services Program:

The Hopi Tribe's Emergency Medical Services (Hopi EMS) program is the sole provider of emergency medical services to the Hopi Reservation and parts of the Navajo Reservation in a rural/wilderness response area nearly two million acres in size. They are responsible for responding to emergency calls for all individuals on the Hopi reservation, Indian and non-Indian alike. The Hopi EMS program is contracted under P.L. 96-638 with the Indian Health Service (IHS) to provide 1.5 EMS crews on a 24-hour basis.

The Hopi EMS program employs seventeen full-time and eight part-time EMS personnel certified by the Arizona Department of Health Services. There are ten paramedics, four intermediate emergency medical technicians (IEMTs), and eleven emergency medical technicians-defibrillator basics (EMTs-D basics). EMS staff members are scheduled to work twelve, twenty-four, and thirty-six hour shift segments. Three ambulances of the fleet of five are equipped continuously for response, with two ambulances assigned to "on duty" crews and a third ambulance reserved for "call back" crew readiness should a medical emergency require a third ambulance. The remaining vehicles are available as reserve or replacement ambulances to allow for scheduled maintenance and repair schedules to occur. Technically, the Hopi EMS program only has enough resources to staff 1.5 full-time crews and needs funding for three full-time crews. At present, overtime is used to compensate for lack of personnel. As emergency call volume increases staff overtime, staff burnout results in an area where it is difficult to find experienced EMS personnel.

During the past five years, Hopi EMS has experienced a growth in the volume of emergency calls of about fifty-seven percent (+/- 10% per year). Should this trend continue, Hopi EMS is projecting an annual call volume of nearly 2000 calls by the year 2004. Roughly, half of the calls are EMS 911-emergency calls and half are inter-facility patient transports either to an air-ambulance or by ground directly to another health care facility ninety to one hundred-twenty miles away.

The Hopi Tribe recently opened a new ambulatory health care center. Although the Center offers a wider array of health services, inpatient capacity is extremely limited (4 beds and 2 birthing beds). With the closing of the seventeen bed inpatient hospital,

most patients requiring inpatient care must now be transported depending on their condition and availability of beds at the ambulatory care center. Inter-facility transports are expected to increase dramatically due to facility capacity.

The Hopi EMS program is financed through an IHS PL 93-638 contract agreement, third party billing, and some additional grant funding. The present revenue available for our program is extremely inadequate to meet the mandated mission and serve the population according to basic industry guidelines.

The Hopi Tribe estimates an urgent need of $505,580 to facilitate the move from an inpatient hospital setting to an ambulatory care setting. The expense of operating a standardized EMS program on the Hopi reservation will run a shortfall of $935,000 unless additional revenue is obtained. The attached budget charts will help the Committee understand this shortfall.

Recommendations for Improving the Present Tribal EMS System:

In 1993, the National Highway Traffic Safety Administration, Technical Assistance Team (NHTSA-TAT), conducted an evaluation of the Indian Health Services EMS program. NHTSA-TAT's basic recommendations included the following: 1) that Congress and IHS officially recognize EMS as an integral part of the health care delivery system for Native Americans; 2) that the IHS budget include an EMS line item that dedicates EMS funding consistent with clearly documented EMS needs by 1995; and 3) that IHS establish an adequately staffed EMS branch within the IHS to assure effective oversight, policy development, and support and advocacy for quality EMS services.

The Hopi Tribes suggests that the following steps be considered as a way to address critical EMS needs:

1) Create an IHS/Tribal task force to review tribal EMS programs and assess overall needs. Examine payments from other public payers for such services.

2) Establish a routine reimbursement mechanism for IHS payment of medically necessary inter-facility transports such as from an ambulatory care center to a hospital.

3) Appropriate additional funds to meet the goal of the President's budget request for emergency medical services. The President's budget request for fiscal year 2001 includes an increase of $2,912,000 to "increase access to effective emergency medical services (EMS) for Indian people by improving the capacity of IHS and tribal programs to provide hospital and pre-hospital EMS." The funds are to be available to all IHS Areas and would be used to expand the capacity of the 70 existing EMS programs that now serve Indian people. The budget summary indicates that the funding will include the training of new emergency medical personnel as well as enhancing the skills of current personnel and upgrading equipment. The funding is also to be used to develop EMS capacity for 1 to 3 tribes that are currently without

EMS systems. The budget request notes that presently an estimated **25 tribes have the need to develop EMS systems.** This budget request acknowledges a clear problem.

4) Appropriate additional funds to shore up grant programs administered by the Department of Health and Human Services Office of Rural Health to expand access to health services in rural communities. This Office has supported grants to pilot test the effectiveness of structured treat and release programs; the concept appears to have promise for other rural communities in providing emergency care.

5) Review the Department of Transportation's experience with Tribal EMS programs. Can an initiative be renewed through the Department to provide funding for training and help establish Tribal EMS programs?

6) Consider the attached legislative language drafted by the Phoenix/Tucson/ Navajo IHS Areas during consultations with Tribes on developing reauthorization language for Indian Health Service programs (see attachment).

Conclusion:

In closing, I draw your attention to the remarks of Richard Flores, President of the Southwest Native American EMS Association. Mr. Flores told an audience that he was "struck by the lack of awareness and needs of Native Americans with regard to funding EMS services" during his visit to Washington, DC last year. He advised his audience to address this gap in knowledge, which in turn has created a gap in funding.

Again, thank you for allowing the presentation of this testimony. We look forward to working with you in the course of your deliberations on legislation to reauthorize and improve health programs for Native Americans. I would be pleased to respond fully to any request for additional information and hope you take a serious look at the ever-increasing need for improved emergency medical services.

Attachment A

HOPI EMERGENCY MEDICAL SERVICES

P.O. BOX 98, KEAMS CANYON, ARIZONA 86034 TEL: 520-738-2211 x 195 – FAX 520-738-5442

FUNDING REQUEST – HHCC TRANSITION - EMERGENCY MEDICAL SERVICES

Hopi EMS respectfully requests an urgent consideration of the following budget requests to be included in the FY 2000 funding of PL 93-638 contract #247-97-0015. Consideration for transition costs incurred by the Hopi Tribe upon accepting the Hopi Health Care Center included in the document "18 Requirements" provision of additional funding for medical transportation. To date, no financial accommodation of this urgent need has been made. Additional costs associated with this transition to the Hopi Health Care Center have been incurred already, the transition to the center is scheduled for the month of June 2000. Your attention to this matter is of the utmost importance to the health and welfare of the Hopi people, their neighbors, and their visitors.

TRANSITION FUNDING — AMOUNT: $ 505,580.00

PRIORITY ONE:

P C	ITEM	JUSTIFICATION	QUAN.	EACH	TOTAL
1	ADDITIONAL STAFFING	TO ACCOMMODATE ADDITIONAL STAFFING REQUIREMENTS FOR MEDICAL TRANSPORTATION NEEDS AT THE HHCC FOR JUNE THROUGH DECEMBER 2000 OR 7/12 OF FY 2000 ($294,846.00 ANNUALLY)	NINE EMS CREW MEMBERS 3-CIP 3-EMT-I 3-EMT-D OVERTIME BENEFITS	$ 180,180.00 53,000.00 46,000.00 38,000.00 3,000.00 32,180.00	$ 180,180.00
2	6pa-VEHICLE LEASE	ESTIMATED LEASING COSTS FOR FOUR AMBULANCES, ONE RESCUE TRUCK, AND ONE ADMINISTRATIVE VEHICLEFOR 7/12 OF FY2000 ($60,000.00 ANNUALLY)	SIX VEHICLES	$ 35,000.00	$ 35,000.00
3	LAB-MEDICAL SUPPLIES	FUNDING TO ACQUIRE INITIAL STOCK REQUIRED FOR NEW TERMS OF AGREEMENT WITH PL 3-638 CONTRACT 7/12 OF FY 2000 ($73,000.00 ANNUALLY)	7 MONTHS	$ 6,000.00	$ 42,000.00
4	CAPITAL EQUIPMENT – (2) 12 LEAD CARDIAC MONITOR DEFIBRILLATORS	THE STANDARD OF CARE FOR THIS REGION INCLUDES THE USE OF 12 LEAD CARDIAC MONITORING. THESE ITEMS WILL BE PLACED ON AMBULANCES AND USED IN THE PREHOSPITAL SETTING BY PARAMEDIC STAFF.	TWO UNITS	$ 28,000.00	$ 56,000.00
X X	TOTAL PRIORITY ONE	MINIMUM FUNDING TO MAINTAIN SERVICE AVAILABILITY FOR FY2000/HHCC TRANSITION	7 MONTHS	$ 36,740.00	$ 313,180.00

PRIORITY TWO:

P C	ITEM	JUSTIFICATION	QUAN.	EACH	TOTAL
5	RADIO SYSTEM MOBILE, BASE, PORTABLES, PAGERS	U.S. GOVERNMENT DOI – BIA IS MANDATING THAT ALL AGENCIES COMMUNICATING ON BIA FREQUENCIES MUST CONVERT RADIO SYSTEMS TO MEET "PROJECT 25" REQUIREMENTS. HOPI EMS	3-BASE STN 4-REPTRS 14-MOBILE 12-PORTAB 23-PAGERS	$ 3,300.00 1,800.00 2,300.00 1,400.00 400.00	$ 9,900.00 7,200.00 32,000.00 16,800.00 17,300.00

		RELIES ON FEDERAL FREQUENCIES FOR DISPATCH AND INTERAGENCY COMMUNICATIONS—NOT COMPLYING TO MANDATE MAY JEAPORDIZE PATIENTS AND EMERGENCY SERVICE PERSONNEL	4-TOWERS	3,600.00	14,400.00
	INSTALLATION		COMPLETE SYSTEM	$ 11,500.00	11,500.00
	TOTAL COST	.....	.....	.....	$ 104,900.00
6	CAPITAL EQUIPMENT – (1) 12 LEAD CARDIAC MONITOR DEFIBRILLATOR	THIRD 12 LEAD CARDIAC MONITOR-DEFIBRILLATOR IS USED AS BACK-UP UNIT AND WILL ALLOW FOR THIRD PARAMEDIC UNIT TO BE DISPATCHED WHEN NEED OCCURS.	ONE UNIT	$ 28,000.00	$ 28,000.00
7	SATELLITE/CELL PHONE SYSTEM	PHONE SYSTEM IS NEEDED TO COMPLETE THE COMMUNICATION SYSTEM TO ALLOW FOR EKG TRANSMISSION, REDUNDANCY FOR MEDICAL CONTROL, AND PERMIT FUTURE DEVELOPMENT OF TELEMEDICAL TECHNOLOGIES.	5 – MOBILE 2-PORTABL INSTALL:	$ 4,000.00 3,500.00	$ 20,000.00 7,000.00 2,500.00 $ 29,500.00
8	LAB-MEDICAL SUPPLIES	NEEDED TO ACQUIRE RESERVE MEDICAL SUPPLIES FOR RESIDUAL AND DISASTER PREPAREDNESS	5 MONTHS	$ 6,000.00	$ 30,000.00
X x	TOTAL PRIORITY TWO	REQUIRED FUNDING TO MEET FEDERAL MANDATES AND SYSTEM DEVELOPMENT REQUIREMENTS			$ 192,400.00

PRIORITY ONE:	$ 313,180.00
PRIORITY TWO	192,400.00
TOTAL REQUEST	$ 506,580.00

HOPI EMERGENCY MEDICAL SERVICES

YEAR 2001 BUDGET SUMMARY

LINE ITEMS	CREW 1	CREW 2	CREW 3	EMS ADM	IHS-638	OTHER	TOTAL	SHORTFALL
SALARIES	253,000.00	253,000.00	253,000.00	92,000.00	351,686.00	54,068.00	651,000.00	445,246.00
OVERTIME	12,000.00	12,000.00	12,000.00	3,000.00	12,000.00	15,000.00	39,000.00	12,000.00
PT-TEMP	20,000.00	20,000.00	20,000.00	6,000.00	-	15,000.00	66,000.00	51,000.00
BENEFITS	79,800.00	79,800.00	79,800.00	26,280.00	101,832.08	23,539.04	267,680.00	142,308.88
TRAVEL/TRNG				40,000.00	-	10,000.00	40,000.00	30,000.00
OFFICE SUPPLIES				10,000.00		2,500.00	10,000.00	7,500.00
PRINTING				4,500.00		2,400.00	4,500.00	2,100.00
GEN.OPERATING				15,000.00		1,500.00	15,000.00	13,500.00
FUEL-OIL-LUBE				12,000.00		4,000.00	12,000.00	8,000.00
CLOTHING				8,800.00		4,000.00	8,800.00	4,800.00
LAB-MEDICAL				25,000.00		5,000.00	25,000.00	20,000.00
OTHER SUPPLIES				9,800.00		2,500.00	9,800.00	7,100.00
UTILITIES				12,000.00		200.00	12,000.00	11,800.00
GARBAGE				800.00		200.00	800.00	400.00
TELEPHONE				3,800.00		2,400.00	3,800.00	1,200.00
EQUIP.RENTAL				6,000.00		100.00	6,000.00	5,900.00
SPACE COST				25,000.00		100.00	25,000.00	24,900.00
VEHICLE LEASE				60,000.00		28,000.00	60,000.00	32,000.00
VEHICLE MAINT.				24,000.00		1,000.00	24,000.00	23,000.00
EQUIP.MAINT.				10,400.00		500.00	10,400.00	9,900.00
CONSULT.PROF.				6,000.00		4,500.00	6,000.00	1,500.00
DUES&SUBSC				600.00		236.00	600.00	364.00
INSURANCE				10,400.00		500.00	10,400.00	9,900.00
VEHICLE PURCH.				35,000.00		5,000.00	35,000.00	30,000.00
FURN. & EQPMT				42,208.12		7,500.00	42,208.12	34,708.12
MISC./CONTING.				10,000.00		4,127.00	10,000.00	5,873.00
TOTAL OPERA	364,800.00	364,800.00	364,800.00	499,988.12	465,518.08	193,870.04	1,884,388.12	935,000.00
CURRENT $	364,800.00	100,718.08	-	193,870.04	465,518.08	193,870.04	659,388.12	935,000.00
REQUESTED	-	264,081.92	364,800.00	306,118.08	-	-	xxxxxxxxxxxxxx	935,000.00

Attachment B

Attachment C

Proposed/Recommended changes to the 437 Reauthorization Legislation related to

Emergency Medical Services

Title II – Health Services

SEC. XXX. (a) The Secretary, acting through the Service, shall provide a specific Indian Emergency Medical Services (EMS) Program that will minimally consist of :

(1) The budget line item appropriation 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 provision of a comprehensive emergency medical service programs to American Indian/Alaskan Native communities.

(2) The appropriation shall cover the provision of ambulances appropriate for the service location, terrain, and level of staff licensure; replacement, repair and maintenance of ambulances are covered within each appropriation.

(3) Staffing and equipment shall be according to national standards and state statues applying to EMS services, of at least–

(a) Three hundred fifty (350) to four hundred (400) ambulance calls would establish the eligibility for a paid EMS staff rather than a volunteer staff using one vehicle with 24 hour coverage.
(b) Each ambulance would be staffed with nine (9) EMS direct care FTE providers and 1.5 administrative FTE.
(c) Number of staff FTEs and equipment will be determined by a national standard need formula based on demonstrated utilization community and health care system need. The results of this formula will determine base funding allocations by program/community.
(d) There shall not be any duplication of EMS services, i.e. competing services for the same Tribal community, funded by this appropriation.

(4) After employment of qualified EMS direct care staff, training costs to renew and/or upgrade EMS staff licensure will be paid by the appropriation of specific funds within this section.

(5) The appropriation line item for Emergency Medical Services shall be within the Hospital and Clinics section of the total Service and cannot be diverted to other health care needs.

(b) The Service shall report to Congress annually on the impact of these Emergency Medical Service appropriations within the American Indian/Alaskan Native communities benefiting from the appropriation.

Muscogee (Creek) Nation

PRINCIPAL CHIEF
R. Perry Beaver

SECOND CHIEF
A.D. Ellis

OFFICE OF THE PRINCIPAL CHIEF
PO Box 580
(HWY 75, Loop 56)
Okmulgee, Ok 74447
918/756-8700

July 26, 2000

The Honorable Ben Nighthorse Campbell, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Bldg.
Washington, D.C. 20515

RE: S. 2526, Section 512 (a) and (b)

Dear Chairman,

In reference to the possible amendment of S. 2526, Section 512 of the proposed measure, (to permanently authorize two ongoing demonstration projects in Oklahoma), we are requesting a hearing on Section 512.

The projects in question are funded through Indian Health Service to provide services in Oklahoma City and Tulsa for the benefit of two independently organized groups of urban based citizens who have no direct relationship to any of the Tribes in Oklahoma, Texas or Kansas.

The Indian tribes of Oklahoma, Kansas and Texas have enjoyed long-term support from their respective Congressional Offices since the enactment of P.L. 93-638, (Indian Self-Determination and Education Assistance Act). This proposed action sets a precedent that is contrary to Self-Determination and Self-Governance for Indian tribes, as well as the intent of all other legislation concerning services for Indian people. As you are aware, services and resources to support those services are tied to federally recognized tribes that have a reservation land base or a previously defined land base, which is a result of individual treaties between tribes and the United States.

The demonstration authorization of funding for Indian Health Service resources, outside the responsibility of the tribes, established the precedent that any group of Indian citizens or individual Indians can have Congress set them up in business independently without honoring the federal/tribal government-to-government relationship. While the two demonstration projects in Oklahoma City and Tulsa have been addressing health care needs, they are clearly absent of any input/or participation of the tribal governments which are authorized to represent the Indian citizens to whom they are providing services.

If these demonstration project clinics are permanent, all Indian Nations in Oklahoma, Kansas, Texas are concerned that your actions would be contrary to existing Self-Determination principles. ***We are requesting field hearings on this issue during the August recess or at a time more convenient before the next Congress convenes.*** ***Attached is proposed language on this issue.***

Sincerely,

R. Perry Beaver, Principal Chief
Muscogee (Creek) Nation

REVISED LANGUAGE PROPOSED TO S. 2526, SECTION 512 (a) OKLAHOMA CITY CLINIC

The Oklahoma City Urban Clinic shall be subject to the authority of Public Law 93-638. Thus, the Oklahoma City Urban Clinic shall be contractible or compactable under the provisions of that law. The Oklahoma City Urban Clinic shall be contractible or compactable only under the auspices of those seven (7) Tribes with historic boundaries surrounding the Oklahoma City area. Those Tribes include: Citizen Potawatomi Nation, Absentee Shawnee Tribe, Iowa Tribe of Oklahoma, Kickapoo Tribe of Oklahoma, Sac and Fox Nation, Cheyenne-Arapaho Tribe and Chickasaw Nation.

The Oklahoma City Urban Clinic shall only be contracted or compacted under P.L. 93-638 through resolution provided to any of the seven affected Tribes, by consensus or by a simple majority (4) of the affected Tribes, or to a consortium of those seven Tribes. It shall be understood that all citizens (users) of the Oklahoma City Urban Clinic shall remain harmless during this process.

REVISED LANGUAGE PROPOSED TO S. 2526, SECTION 512 (b) TULSA CLINIC

The Tulsa Urban Resource Center, Indian Health Clinic, shall be subject to the authority of Public Law 93-638. Thus, the Tulsa Urban Resource Center shall be contractible or compactable under the provisions of that law. The Tulsa Urban Resource Center shall be contractible or compactable only under the auspices of two (2) Tribes with historic boundaries in the Tulsa City area. Those Tribes include: Cherokee Nation of Oklahoma and Muscogee (Creek) Nation.

The Tulsa Urban Resource Center shall only be contracted or compacted under P.L. 93-638 through resolution provided by the two affected Tribes. It shall be understood that all citizens (users) of the Tulsa Urban Resource Center shall remain harmless during this process.

HOBBS, STRAUS, DEAN & WALKER, LLP
LAW OFFICES
2120 L STREET, N.W., SUITE 700
WASHINGTON, D.C. 20037
(202) 822-8282
FAX (202) 296-8834

CAROL L. BARBERO (DC)
NICOLE BAZAN (NY)
S. BOBO DEAN (DC, NY)
CHARLES A. HOBBS (DC)
CRAIG A. JACOBSON (OR, WA)
WILLIAM R. NORMAN, JR. (DC, OK)
STARLA K. ROELS (OR)
MICHAEL L. ROY (DC)
LISA F. RYAN (DC)
MARSHA KOSTURA SCHMIDT (DC)
JUDITH A. SHAPIRO (DC)
DAVID D. SHAW (OR, WA)
JERRY C. STRAUS (DC)
GEOFFREY D. STROMMER (AZ, OR)
HANS WALKER, JR. (DC)
JOSEPH H. WEBSTER (DC)
F. MICHAEL WILLIS (DC, MD)

851 S.W. SIXTH AVENUE, SUITE 1500
PORTLAND, OREGON 97204
(503) 242-1745
FAX (503) 242-1072

EXECUTIVE SUITES BUILDING
2750 WEST MAIN
NORMAN, OK 73072
(405) 360-8488
FAX (405) 360-8488

OF COUNSEL:
C. BRYANT ROGERS (NM, MS)
DEAN B. SUAREZ (DC)

LEGISLATIVE AFFAIRS:
KAREN J. FUNK
R. AURA KANEBIS
MARIE OSCEOLA-BRANCH

August 14, 2000

Honorable Ben Nighthorse Campbell
Senate Committee on Indian Affairs
Room 838 Senate Hart Building
United States Senate
Washington, DC 20510

RE: S. 2526

Dear Chairman Campbell:

We write on behalf of the Bristol Bay Area Health Corporation to make clear its position on a provision in S. 2526. Section 406(g) of the bill permits tribal health care programs funded under the Indian Self-Determination and Education Assistance Act to recover reimbursement for health services provided to employees of Indian tribes or tribal organizations from tribally self-insured employee health plans only with the consent of the tribal employer.

This additional provision was not included in the bill as recommended by the National Indian Steering Committee. We participated actively as a representative of BBAHC in the many national and regional consultations which produced the Steering Committee draft. To our recollection no tribal representative every proposed such a provision. Our client is not aware of any tribe or tribal organization which had recommended this change in the bill.

We also participated in the development of testimony for the hearing on July 26 to be submitted by the Steering Committee. At that meeting it was determined that the Steering Committee would recommend the deletion of this provision in section 406(g) since that Steering Committee was not aware of any tribal support for the provision and considerable tribal opposition had been voiced.

We understand that, while no Steering Committee representative was asked to testify on Title IV at the July 26 hearing, a statement has been prepared, including a recommendation for the deletion of this provision, but that it was not cleared in time for submittal prior to the deadline last Friday, August 11.

While we have been assured that this Steering Committee statement will be filed for the record of the recent hearing in Bismarck, North Dakota, on the bill, we are submitting this letter on behalf of our client, the Bristol Bay Area Health Corporation, in order to assure that its position is reflected in the record. BBAHC provides health services in the 45,000 square mile Bristol Bay region of Alaska, and operates the Kanakanak Hospital in Dillingham, Alaska. It depends for tertiary in-patient care on the Alaska Native Medical Center which is now operated under the Indian Self-Determination and Education Assistance Act by the Alaska Native Tribal Health Consortium, a coalition of tribes and tribal organizations which includes BBAHC and its member tribes. In BBAHC's view, the ability to recover for health services provided to Indian and Alaska Native employees of tribal organizations which self-insure as allowed by existing law and the Steering Committee bill is critical for the financial viability of the ANMC. BBAHC urges that your Committee follow the Steering Committee recommendations with respect to the wording of section 406(g).

We respectfully request that this letter be included in the record of the hearing on July 26 and express our appreciation in advance for your willingness to do so.

Sincerely yours,

HOBBS, STRAUS, DEAN & WALKER, LLP

By: S. Bobo Dean

cc: Senator Inouye, Attn: Patricia Zell
Senator Stevens, Attn. Elizabeth Connell
Senator Murkowski, Attn: Amy Bannon
Congressman Don Young, Attn: Cynthia Ahwinona
H. Sally Smith
Robert Clark
Rachael Joseph
Buford Rollin
Myra Munson

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Grand Ronde Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoshone-Bannock Tribe
Siletz Tribe
Skokomish Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

527 SW Hall
Suite 300
Portland, OR 97201
☎ (503) 228-4185
FAX (503) 228-8182
www.npaihb.org

July 26, 2000

Senator Ben Nighthorse Campbell and Senator Daniel Inouye,
Senate Indian Affairs Committee
Hart Senate Office Building
Washington, DC 20510

Dear Senators Campbell and Inouye,

Thank you for this opportunity to provide testimony on the Indian Health Care Improvement Act. Tribes nationwide appreciate your efforts in holding the Senate Indian Affairs Committee's third hearing on proposals to amend and reauthorize P.L. 94-437. I was privileged to testify in person at the May 10, 2000 hearing where I was asked to comment on Title III, the facilities title. I would like to limit my comments today to Title IV, the Access to Health Services Title of the Indian Health Care Improvement Act.

The Northwest Portland Area Indian Health Board has been an active participant in both the current law (P.L. 94-437) provisions relating to Medicare and Medicaid contained in Title IV and the proposed changes reflected in Senate Bill S. 2526.

The purpose of Title IV is to allow American Indians and Alaska Natives full access to the health programs administered by the Health Care Financing Administration. As you know these programs include the Medicare, Medicaid and Children's Health Insurance Programs. In addition, Title IV grants authority to Indian health programs to bill and be reimbursed for services provided to eligible American Indians and Alaska Natives.

Title IV is a complex title that addresses issues fully understood by only a handful of health policy experts. The National Steering Committee benefited from the work of many Indian Health Service, tribal, urban and Health Care Financing Administration staff and tribal attorneys in the development of the proposed Title IV in S. 2526. Yet amidst this complexity, the title really has only two goals: First, to guarantee Indian people access to the Health Care Financing Administration's programs and secondly, to ensure that Indian health programs are paid for services provided to eligible American Indians and Alaska Natives (and in certain instance other non-Indian patients).

Of course, beyond the two related goals of the title lies the complexity of the programs themselves and their interaction with an equally complex Indian health system of health care delivery and finance. Consider how Medicaid, a means-tested health insurance program, financed jointly by states and the federal government, but administered by states according to federal policies interacts with the Indian Health Care system. First, imagine how one of my

Nez Perce Indian elders feels when being interviewed about her finances as a condition of receiving her contract health care-purchased services. It is required that we do so by Indian Health Service policy and as a practical matter to increase our revenues. Second, you can imagine how a tribal leader reacts when told that a shift in state of Idaho policy can mean fewer rather than more dollars in income from Medicaid. In both cases the sense that a federal obligation to our tribe has been violated leaves our people confused and questioning why do leaders like myself continue to work on Medicaid issues. I ask the same question myself and continue to advocate for entitlement status for Indian health, but I know that we must, for the time being, improve our relationship with the Health Care Financing Administration programs. That is what we have tried to do in Title IV.

The Northwest Portland Area Indian Health Board and its member tribes have a great deal of experience with Medicaid and the much smaller Children's Health Insurance Program. In fact, last June we were invited by the National Steering Committee to share our experience in a presentation to the committee that detailed current Medicaid practices in our states of Oregon, Washington, and Idaho. That presentation listed many of our existing practices that became the new amendments to the act to promote access to Health Care Financing Administration programs and guarantee payment to Indian health programs. These practices were established with hard-fought negotiations in our states with Medicaid programs and the Health Care Financing Administration. The practices include: exemptions from estate recovery, exemption from cost sharing, prohibition of automatic assignment to non-Indian providers or managed care plans, payment for out-of-plan services when an American Indian does choose a managed care plan as their primary provider, payment of the federal all-inclusive encounter rate for services such as dental, mental health and alcohol and substance abuse treatment, payment (and reimbursement to states at the 100% Federal Medical Assistance Percentage) for services beyond the four walls of our facilities, and other important agreements that all share the goal of increasing access to American Indians and Alaska Natives and guaranteeing fair payment to Indian health programs.

Let me repeat that these Medicaid practices are examples of our accomplishments under the current act. Why then did we work to include changes in the reauthorization bill? The answer is because tribes in other areas told our tribes that our accomplishments were good ones, but in most cases not achievable in their states. We were asked to document our practices and work to codify them in the reauthorization bill together with other model practices in states such as Alaska. By placing them in the new Indian Health Care Improvement Act these practices will not depend on the whim of state politics or changes in views of the Health Care Financing Administration. Our own self-interest also makes us a strong a supporter of these changes because we know these practices are successful but we also

know the political support behind them is tenuous. All tribes, including our own, will benefit from making permanent law what is now simply a matter of policy.

Finally, proposed changes to the Medicare program will correct the disgraceful record of this program in serving Indian people. In my view, the authority for Indian Health Service clinics to bill Medicare should not have to wait for the bill to pass. Couldn't this change be made in a technical amendment to some other bill or report language for the Interior Appropriations bill (HR 4578)?

I would also hope that the committee continues to work for the elevation of the Indian Health Service Director to Assistant Secretary for Indian Health in the Department of Health and Human Services rather than wait for this change to take place as a new provision of Title VI.

Thank you again for the opportunity to share our views with the committee. The Northwest Portland Area Indian Health Board continues to keep our member tribes informed on the progress of the Indian Health Care Improvement Act and we stand ready to assist the committee until the reauthorization bill is passed. If you have any questions please contact me or our staff for the act, Ed Fox at 503-228-4185.

Sincerely,

Ed Fox for J.A.D.

Julia A. Davis

Albuquerque Metro Native American Coalition (AMNAC)
P.O. Box 1571
Albuquerque, New Mexico, 87103
Phone: (505) 291-1880
e-mail: mokohoko@aol.com

July 19, 2000

The Honorable Pete Domenici
U.S. Senator
328 Hart Senate Office Building
Washington, DC 20510

Dear Senator Domenici:

I am appealing for congressional attention and interest to the diminishment of services of the Indian Health Service (IHS), Albuquerque Servicing Unit (ASU) and the imminent closure of the IHS, Southwest Indian Polytechnic Institute (SIPI) Dental Program.

Health care for the 30,000 Urban Indians living in Albuquerque is a dismal reflection of the commitment that the United States government brings to its trust responsibility. The primary federal agency that has responsibility for the provision of health care for Native Americans and Alaska Natives is the Indian Health Service, which is part of the U.S. Department of Health and Human Services. The Albuquerque Service Unit, which is a part of the Albuquerque IHS Area Headquarters is located in the city and has been delivering health care services and programs to the 27 tribes in the area as well as the urban Indian population. However, in the past six years, there has been a steady and surreptitious erosion of services to the urban Indian population by the IHS. This has occurred through a series of funding management problems, diversion of funds to other than patient care priorities, avoiding the health care needs of the urban Indians by abolishing approximately 16 health care positions and mainly the local tribes exercising greater self-determination over their health service to bring the delivery systems to their home communities.

The Albuquerque urban Indians have no quarrel with the local tribal governments exercising greater self-determination, in fact, we encourage it. However the latest withdrawal of the "tribal-funding shares" in FY 2001 will force closure of the SIPI/IHS Dental Clinic. Moreover, it will leave the majority of Native Americans residing in Albuquerque without even the most basic dental services to relieve pain and suffering, let alone broader service to maintain sound dental health. Compounding our concerns is that out of approximately 5,000 Indian students enrolled in the Albuquerque school districts, only 1,073 received SIPI/IHS Dental Clinic services in 1998. Albuquerque children not using dental services is an unbelievable 79%! Again, this reverts back to the lack of funds to reach the American Dental Association recommended ratio of 1 dentist per 2,000 population. SIPI/IHS Dental Clinic's ratio of full time dentists is 1 to 30,000.

There does not appear to be any real commitment from the Indian Health Service to improve or restore health care services to the urban Indians in Albuquerque except to engage in lengthy discussions and rhetoric about "partnerships" which have been going on for over 2 years. There has been no attempt by IHS to request additional appropriation for this large group of Native Americans. (The Indian Health Service reports that, although over 65% of Native Americans live in an urban setting, less that 1% of the IHS budget is distributed for their care.) In the meantime, the health care "rug" is slowly and assuredly being cut away from people who can least afford to pay for health care.

The Albuquerque urban Indian population numbers have been used to justify the budget for the Albuquerque Service Unit and then the tribal entities in the ASU catchment area are permitted to divide up the "urban-inflated" funding utilizing the tribal population as a percentage of the whole budget without considering that the tribal user population (13,134) is not accurately represented in terms of percentage of the whole Native American population served. The 1997 IHS service statistics show that of the 85,854 visits to IHS facilities, urban Indians made 72,720 of those visits generating over $13.4 million of the $16.6 million recurring dollar distribution to the local ASU tribes. Without the urban Indian service population numbers, the amount of the whole budget would be smaller ($3.2 million vs $16.6 million) and therefore, the tribal shares would be smaller. The urban Indian population receives zero dollars of $16.6 million distribution. **If Albuquerque urban Indians were counted as part of the total service population that IHS cited when collecting Snyder Act Funds from Congress, the Albuquerque urban Indians should also be recipients of the equitable division of those funds. (Reference Rincon Band of Mission Indians v. Califano, 464 F. Supp 934 (N.D. cal. 1979)**

I am asking for your assistance to make an congressional inquiry into why IHS couldn't change the status of the SIPI Dental clinic back to its original charter as an all nations dental clinic for the purposes of establishing a dental training facility and a dental service clinic for the 30,000 urban Indian population which includes over 5,550 SIPI, Albuquerque Public Schools and University of New Mexico students. This request is not asking for a unique situation, the Haskell Indian Nations University (formally Haskell Institute) has an all nations health and dental clinic which dates back beyond 1950's and has direct funding that is not subservient to the local tribes and is not under the auspices of P.L. 93-638.

I am also requesting that during the Senate hearing on the rewrite of P.L. 94-437 you consider introducing this written testimony from Albuquerque Indian community. Because this group feels so strongly that the trust responsibility is being violated and that accountability and responsibility is not being taken seriously by the IHS, we are asking that amendments to the P.L. 94-437 include references to urban Indian communities such as Albuquerque ensuring funding for that group in the future. Except for Title V under P.L. 94-437, urban Indian communities do not have direct access to the funding provided to existing Indian Health Services facilities in urban areas. Title V also only provides funding directly to urban Indian organizations and not to existing urban IHS facilities. Urban Indians, especially in Albuquerque, desire to continue to obtain their health care through existing IHS facilities.

It is imperative that intense congressional attention be made to the urban Indian health issues in Albuquerque and to the methods that the IHS utilizes in addressing and funding the health care needs of this large population.

Specifically I request that you support legislation to appropriate supplemental recurring funds be introduced and passed to support the SIPI Dental Program as a federally staffed program at the 1994 level of service (for the next 3 fiscal years) which is approximately $2.7 million dollars annually. It is imperative that such appropriations for the SIPI Dental Program be dedicated, line-item budgets for the urban Indian populations and be treated as a service unit in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance. There should also be periodic reports required of the IHS to appropriate congressional groups to assure the integrity of such expenditures.

I would appreciate you making this letter a part of the hearing record before the Senate committee hearing on P.L. 94-437 rewrite and the Senate Appropriations subcommittee.

Your continued interest and support is greatly appreciated. Feel free to contact Emmett Francis at (505-768-3000) or Keith Franklin at (505) 291-1880 regarding this matter. Thank you very much.

Sincerely,

Keith E. Franklin

Keith E. Franklin, Chairman

CHEYENNE RIVER TRIBAL NATION POSITION PAPER

ON THE REAUTHORIZATION AND REVISIONS

TO THE INDIAN HEALTH CARE IMPROVEMENT ACT

The reauthorization of this legislation is essential to the efforts of all Tribal Nations to continue the process of improving the health care of our Tribal members.

To briefly summarize, we strongly support the Government-to-Government Consultation process and the proposed amendments. We strongly urge Congress to increase appropriations to a level consistent with that provided to the nation as a whole and would hope Congress will see fit to fund those sections that have been authorized but never funded.

In these times of prosperity, it is heartbreaking to watch our people continue to suffer from diseases whose rates can only be compared to those of some of the more disease ravaged Third World Countries. In this period of extended budget surpluses, we urge Congress to utilize a portion of this surplus to raise the level of funding for Indian Health programs which in this area are funded at less than 50% of the known unmet needs. This results in suffering and early death for many tribal members. We feel the Indian Health Service goal of "Raising the Health Status of the Indian people to the highest level" is innocuous and should be more specific i.e. "at least to the same level as the health status enjoyed by the rest of the nation".

The IHCIA along with the Snyder Act is the legislation at the core of the Federal Government's responsibility for meeting the health needs of AI/AN. Since this legislation contains a wide ranging list of provisions, many of which have significant budget and management implications across Indian Country, a thorough review and careful consideration are necessary to ensure continued improvement of Indian health care. Specifically we will address each title individually as it relates to issues that affect the daily lives of our Tribal members and impacts upon their health and welfare.

TITLE I - INDIAN HEALTH HUMAN RESOURCES AND DEVELOPMENT

We certainly support the two-fold purpose of this title:

1.) To increase the number of Indian students entering the health professions; and,

2.) To assure an adequate supply of health professionals to the Indian Health Service and to Urban and Tribal Health delivery systems.

Of particular interest is new language added in section 116 to require that "appropriate employees" undergo instruction in the culture and history of the Tribe whose members they provide services to, which would be provided by tribal colleges, if possible. The cultural sensitivity training may be more appropriately provided by Tribal Councils. This should greatly reduce staff turn over amongst non-member medical staff.

We would support language to require Title I recipients to fulfill their scholarship and job placement requirements in the areas from which they receive their scholarship assistance.

We also strongly support language that would designate all programs operated by Tribes as health profession shortage areas. Tribal Health profession staffing needs must be given consideration on an equal basis with programs operated by the Indian Health Service. There should be no change for those students already in the "pipeline" regarding their priority status.

TITLE II - HEALTH SERVICES:

We fully support the goals of Section 201, which would reinstitute the Indian Health Care Improvement Fund. Section 201, "(a)" (5) Augmenting the Ability of the Services to meet the following health service responsibilities with respect to those Indian Tribes with the worst level of health status and resource deficiencies in the following categories:

(A) Clinical Care

(B) Preventive Health

(C) Dental Care

(D) Mental Health

(E) Emergency Medical Services

(F) Treatment and Control of/and rehabilitative care related to alcohol and drug abuse.

This must surely have been written specifically for the "Aberdeen Area" in general and each of the Tribal Nations in this area in particular. Unfortunately, the Aberdeen Area Indian Health Service and Tribal Health patients suffer from the worst health status and have the greatest resource deficiencies in the nation. It is estimated this area is funded at 47% of the amount the Indian Health Service calculates as the resources needed to fund

100% of the Area's known health needs. It seems so unconscionable that as we enter the twenty- first century in a nation with unprecedented prosperity that Native Americans continue to be afflicted by disease at rates much greater than other races; they continue to suffer more and longer; and many die decades earlier than they should because they lack access to health care that is adequate.

Year after year studies have revealed that prevelance of Diabetes amongst Indian people has increased at an alarming rate. Type II (Onset) Diabetes is epidemic amongst younger tribal members. Recently a thirteen (13) year old female member was diagnosed with Type II Diabetes. On average, three (3) additional tribal members are diagnosed per week with Type II Diabetes. It is believed that many, many more are in a state of denial. Complications of this dreaded disease continue to devastate many members of our Tribal Nations.

Historically, Diabetes was unheard of in Indian Country, before we were subjected to an abrupt change in our lifestyle. We were the healthiest people on Earth. We were highly mobile, subsisting on a diet rich in protein and low in carbohydrates.

Studies have indicated our Indian bodies react differently to carbohydrates, fats and sugars. Therefore, research done on the effects of Diabetes on Indian people must be conducted on Indian people to have meaningful results.

We strongly support the goals of Section 204 that would make model Diabetes programs recurring through the Year 2012. We urge Congress and the Administration to be generous with resources to implement this section in a meaningful way to prevent and control Diabetes.

The Cheyenne River Sioux Tribal Nation strongly supports the revision to Section 204 which includes Authority for funding to establish, equip and staff kidney Dialysis programs to treat the burgeoning number of diabetics suffering from renal failure.

This area continues to receive less than its equitable share of Indian Health Service funds because of the capitation based funding formula adopted by Indian Health Service Headquarters. A capitation-based distribution formula penalizes us because of the high percapita usage of health services in the Aberdeen Area. To correct this inequity, we strongly encourage language that would mandate the usage of weighted health status; particularly, years of productive life lost (YPLL) by Indian Health Service. We strongly recommend that area offices consult with local Tribal Nations regarding fund distribution rather than relying upon the central office to make the distribution on their behalf.

We strongly support the expanded services in Section 213 to include hospice care, assisted living, long-term health care and traditional health care.

The Cheyenne River Sioux Tribal Nation operates the only EMS services within a 50 mile radius. The program is seriously under funded as the primary link to our outlying communities for patients with emergency health care needs. This constitutes a serious breach in our health delivery system. Therefore, we urge Congress to appropriate sufficient EMS funding as a recurring line item in the budget.

We support all other sections of Title II and urge Congress to fund the appropriate sections in a meaningful way.

The Cheyenne River Sioux Tribe opposes the current Indian Health Service Contract Health Care Priority System as being neither economically sound nor conducive to the provision of quality health care. The Cheyenne River Sioux Tribal Nation urges Congress to establish a committee which includes consumers to research the devastating affect this priority system is having on the ability of our patients to access health care at the most appropriate time to insure the most desirable medical outcome in the most cost effective way.

TITLE III - FACILITIES:

We appreciate Congress' commitment to continue to expend funds for the planning, design, construction and renovation of health facilities on behalf of Tribal Nations.

The Cheyenne River Sioux Tribal Nation, along with others in this area, is in dire need of expanded health care facilities with sufficient staff to meet the current demands for outpatient and inpatient services. Limited health care capabilities of our local facility together with limited Contract Health Care dollars leaves many patients with no access to health care for extended periods of time. This phenomenon results in needless patient suffering and premature death in many cases.

We support the various sections of Title III including the requirement for Tribal Consultation in all facility issues and the language encouraging Tribal Nations to become creative and innovative in their approach to facility construction. To further enhance this

section, we urge Congress to support the design and construction of inpatient facilities under the Joint Venture Health Facilities Demonstration program.

With regard to the establishment of a facility priority system by the Secretary, we recommend the establishment of a base-funding amount to ensure the completion of those facilities that have gone through the process of review and approval. It is our position that because many Tribal Governments have spent years getting their project on the list, it would be unfair to those Tribes to amend the priority system at this time.
It is also our position that greater emphasis should be given to unmet health needs and health status and more weight placed on remoteness in establishing a health care facility priority list.

We also urge Congress to consider the total need of all Tribal Nations when determining facility needs even though those with critical needs may exceed ten in any one of the stated categories. Congress should adopt this policy initially until the playing field is leveled before placing a limit on the number of facilities it will consider for funding in each category in each reporting period.

TITLE IV - ACCESS TO HEALTH SERVICES:

We support the provisions in this title that attempt to eliminate barriers which prevent Indian Health Service, Tribal Nations and Urban organizations from fully accessing reimbursement from other Federal Programs including Medicaid, Medicare and Children's Health Insurance Program (CHIP).

Severe and longstanding lack of adequate appropriations to Indian Health Service require that alternative funding be accessed to the maximum extent possible.

Recently the South Dakota State Legislature extended a moratorium on licensure of long-term health care (nursing home) facilities. Because a state license is required as a preliminary condition of eligibility to receive reimbursement for services provided to eligible beneficiaries under Medicare/Medicaid, the Tribal Nations in this State have been effectively blocked from participating under Title XVIII and Title XIX of the Social Security Act.

Many of our Elders are being denied long-term health care and other elderly health care because this care is not available on the Reservation.
Most Indian elders are opposed to leaving their families to travel hundreds of miles to surrounding non-Indian communities for long-term health care but they must because this is not available locally.

Therefore, the Cheyenne River Sioux Tribal Nation strongly supports direct reimbursement of services provided to eligible beneficiaries of Medicare and Medicaid for long term health care, assisted living health care and other elderly health care. Direct reimbursement from HFCA to Indian Health Service and Tribes for long term health care, assisted living health care and other elderly health care programs under terms that waive all cost sharing for eligible beneficiaries served by Indian Health Service or Tribally managed long term health care facilities under Medicare, Medicaid or CHIP is critical to

ensure that Indian health programs have fair access to all Federal funding sources and the opportunity to modernize their programs to address the needs of and to fulfill the responsibility of the United States to Indian people.

Also, the Cheyenne River Sioux Tribal Nations support language that would permit Tribal Health programs to bill for and receive reimbursement for services provided to eligible beneficiaries under Medicare and Medicaid even when the facility in which these services are provided is owned by the Federal Government.

TITLE V - HEALTH SERVICES FOR URBAN INDIANS:

We appreciate and strongly support Congress' efforts to make quality health care available to Tribal members, who for whatever reason, choose to live in Urban areas. We favor language proposed to permit urban programs to receive lump sum payments for Indian Health Service contracts or grants under the title and to use carry-forward funding from one year to the next.

TITLE VI - ORGANIZATIONAL IMPROVEMENTS:

We urge Congress to act quickly to elevate the Director of Indian Health Service to an Assistant Secretary for Indian Health. With respect to the appointment of an Assistant Secretary for Indian Health appointed by the President with the advice and consent of the Senate, we support language that would require consultation with Tribal Governments prior to and during the appointment process with Tribal Governments being given the

opportunity to submit the names of qualified individuals, one of which will be selected by the President and the Senate.

TITLE VII - BEHAVIORAL HEALTH PROGRAMS

As we enter a new millenium it is heart-rending to be continually reminded of the "Grim Statistics in Indian Country"; e.g. Native American disease rates compared to all other races:

1. Alcoholism	**627% Greater**	**4. Accidents**	**204% Greater**
2. Tuberculosis	**533% Greater**	**5. Suicide**	**72% Greater**
3. Diabetes Mellitus	**249% Greater**	**6. Homicide**	**63% Greater**

While these overall statistics are alarming, more alarming still is the fact that the Aberdeen Area patients' health status is much worse than the average for the Indian Health Service as a whole due to the inequity inherent in the Indian Health Service distribution methodology which is primarily per capita driven.

These grim statistics continue to reflect the effect of cultural oppression, loss of traditions, a long history of forced internment on Reservations and a drastic change in lifestyle for our people; however, we feel it is time for us to join hands and resolve to improve upon the health status of the members of all Tribal Nations.

The aim of this title appears to attempt to integrate substance abuse, mental health and social services into wholistic behavioral health programs. The Cheyenne River Sioux Tribal Nation has consistently taken the leadership role in addressing the myriad of needs

associated with behavioral health problems; therefore, we strongly support integrating programs which are nurturing, fulfilling, accountable and responsible in offering significant opportunities for all Tribal Nations to enjoy wellness through a balance of modern medicine and traditional beliefs and treatments.

We urge Congress to provide adequate funding to begin to make significant measurable improvements in health status in the Aberdeen Area Indian health care.

TITLE VIII - MISCELLANEOUS

The Cheyenne River Sioux Tribal Nation strongly supports the establishment of a commission to study the questions which need to be resolved in defining entitlement and to making health care an entitlement as opposed to discretionary funding. As Treaty Tribes, we believe that health care is an entitlement by virtue of these treaty rights and as ratified by passage of the Snyder Act by Congress in 1921.

Of the twelve Indian Health Service areas, the Aberdeen Area IHS, comprised of North Dakota, South Dakota, Nebraska and Iowa, suffers from higher disease rates, and is under resourced to a greater extent than other areas. These factors combine to place an added burden on an already strained health delivery system.

Health care in this area is so inadequate that the life expectancy amongst tribal member is 6 years less than the IHS average and 12 years less than the national average. Diabetes is occurring at epidemic rates, even among juveniles. Amputations from diabetes complications are occurring at an alarming rate and Tuberculosis has once again become a threat to the lives of our members, largely because of lack of an adequate health facility

that is sufficiently staffed to provide daily patient care. This all points out the need for additional resources to improve health care in the Aberdeen Area.

Thank you for allowing the Cheyenne River Sioux Tribal Nation to express its opinion with regard to this important piece of legislation, its reauthorization and various amendments thereto. We urge Congress, as you consider this legislation, to consider the consequences to Indian people of continued under resourcing of our health programs.

CHAIRMAN
Gregg J. Bourland

SECRETARY
Colette LeBeau Iron Hawk

TREASURER
Benita Clark

VICE-CHAIRMAN
Louis DuBray

P.O. Box 590
Eagle Butte, South Dakota 57625
(605) 964-4155
Fax:(605) 964-4151

TRIBAL COUNCIL MEMBERS

DISTRICT 1
Raymond Uses The Knife Jr.
Juanita Young

DISTRICT 2
David Hump

DISTRICT 3
Maynard Dupris
Edward Widow

DISTRICT 4
Mark Knight
Harold Frazier
Frank Thompson
Arlee High Elk

DISTRICT 5
James Chasing Hawk
Arlene Thompson
Lanny LaPlante
Robert Chasing Hawk

District 6
Michael Rousseau
Louis DuBray

TRIBAL MEMORANDUM

TO : SUPERINTENDENT, Cheyenne River Agency

FROM : Colette LeBeau Iron Hawk, Tribal Secretary DATE: 7/12/00

SUBJECT: RESOLUTION NO. 159-00-CR: Authorizes the submittal of a document entitled the "CHEYENNE RIVER TRIBAL NATION POSITION PAPER ON THE REAUTHORIZATION AND REVISIONS TO THE INDIAN HEALTH CARE IMPROVEMENT ACT," as our official comments relative to this proposed legislation.

Transmitted herewith are an original and two (2) copies of Resolution No. 159-00-CR, which was duly adopted by the Cheyenne River Sioux Tribal Council, during its Regular Session held on July 7, 2000.

CIH/wc
CC: Chairman
Treasurer
Administrative Officer
Council Representatives
District Officers
Central Records
Tribal Health Director
File/2

The blue represents the thunder clouds above the world where live the thunder birds who control the four winds. The rainbow is for the Cheyenne River Sioux people who are keepers of the Most Sacred Calf Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for all the other Indian Nations. The yellow hoops represent the Sacred Hoop, which shall not be broken. The Sacred Calf Pipe Bundle in red represents Wakan Tanka - The Great Mystery. All the colors of the Lakota are visible. The red, yellow, black and white represent the four major races. The blue is

RESOLUTION NO. 159-00-CR

WHEREAS, the Cheyenne River Sioux Tribe of South Dakota is an unincorporated Tribe of Indians, having accepted the provisions of the Act of June 18, 1934 (48 Stat. 984); and

WHEREAS, the Tribe, in order to establish its tribal organization; to conserve its tribal property; to develop its common resources; and to promote the general welfare of its people, has ordained and established a Constitution and By-Laws; and

WHEREAS, Congress is currently considering the Indian Health Care Improvement Act Reauthorization of 2000; and

WHEREAS, the Indian Health Care Improvement Act along with the Snyder Act is the core of the Federal Government's responsibility for meeting the health needs of all eligible Native Americans; and

WHEREAS, the Aberdeen Area Indian Health Service and tribally managed health programs are seriously under-resourced, causing our people to be afflicted by disease at rates much greater than other races and to suffer more and die much earlier than they should because they lack adequate health care; and

WHEREAS, it is important that we influence the Amendments to this Act to the greatest extent possible, to improve on health care throughout Indian Country; now

THEFORE BE IT RESOLVED, that the Cheyenne River Sioux Tribe does hereby authorize the submittal of a document entitled the "CHEYENNE RIVER TRIBAL NATION POSITION PAPER ON THE REAUTHORIZATION AND REVISIONS TO THE INDIAN HEALTH CARE IMPROVEMENT ACT," as our official comments relative to this proposed legislation.

RESOLUTION NO. 159-00-CR

Page Two

CERTIFICATION

I, the undersigned, as Secretary of the Cheyenne River Sioux Tribe, certify that the Tribal Council is composed of fifteen (15) members of whom 11, constituting a quorum, were present at a meeting duly and regularly called, noticed, convened and held this 7th day of July, 2000, Regular Session; and that the foregoing resolution was duly adopted at such meeting by an affirmative vote of 11 for, 0 against, 0 not voting and 4 absent.

Colette LeBeau Iron Hawk, Secretary

Cheyenne River Sioux Tribe

CHAIRMAN
Gregg J. Bourland

SECRETARY
Colette LeBeau Iron Hawk

TREASURER
Benita Clark

VICE-CHAIRMAN
Louis DuBray

P.O. Box 590
Eagle Butte, South Dakota 57625
(605) 964-4155
Fax:(605) 964-4151

TRIBAL COUNCIL MEMBERS

DISTRICT 1
Raymond Uses The Knife Jr.
Juanita Young

DISTRICT 2
David Hump

DISTRICT 3
Maynard Dupris
Edward Widow

DISTRICT 4
Mark Knight
Harold Frazier
Frank Thompson
Arlee High Elk

DISTRICT 5
James Chasing Hawk
Arlene Thompson
Lenny LaPlante
Robert Chasing Hawk

District 6
Michael Rousseau
Louis DuBray

May 31, 2000

Mr. Lee Robinson, IHS
Division of Facilities and Environmental Engineering
12300 Twinbrook Parkway Suite 600 C
Rockville MD 20852

Mr. Robinson:

In response to your "Dear Tribal Leader" letter relative to "Supportable Space" and whether we should continue to "grandfather" certain facilities that exceed the allowable floor space.

We can not support your proposal to continue to provide additional funding to some facilities at the expense of others. This flies in the face of IHS' attempts to develop an equitable distribution formula for area budgets.

The primary concern here has to be equity. Any formula that permits some Tribes to receive a disproportionate share of funding must be discontinued in favor of a formula based on the same criteria for everyone.

Thank you for the opportunity to provide comment.

Sincerely,

Gregg Bourland, Chairman
Cheyenne River Sioux Tribe

The blue represents the thunder clouds above the world where live the thunder birds who control the four winds. The rainbow is for the Cheyenne River Sioux people who are keepers of the Most Sacred Calf Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for all the other Indian Nations. The yellow hoops represent the Sacred Hoop, which shall not be broken. The Sacred Calf Pipe Bundle in red represents Wakan Tanka - The Great Mystery. All the colors of the Lakota are visible. The red, yellow, black and white represent the four major races. The blue is

June 21, 2000

Dear

As Chairman of the Cheyenne River Sioux Tribal Nation, I have long been concerned with regard to the inadequate health care provided to the people of the Cheyenne River Reservation.

Our people continue to suffer from disease rates that are far in excess of those of the Nation as a whole and even exceed the rates of other areas of the Indian Health Service. Recently, this situation appears to have worsened, especially as it relates to in-patient care capabilities.

We strongly urge you to keep this in mind as you begin the task of deciding the future of our Tribal Nation's health care through the reauthorization of this important legislation.

We have attempted to address major issues that will have the greatest impact on our Tribal Nation's health status. Realize these comments are provided in all sense of fairness and sincerity and we trust you will consider them in that same regard.

We as a Tribal Nation stand ready to assist you any way we can to alleviate premature death and suffering amongst our people resulting from a failure by Congress to adequately fund Indian health programs.

If you should need additional information, please contact my office.

Sincerely,

Gregg J. Bourland, Chairman
Cheyenne River Sioux Tribe

CHEROKEE NATION
P.O. Box 948
Tahlequah, OK 74465-0948
918-456-0671

Chad "Corntassel" Smith
Principal Chief

Hastings Shade
Deputy Principal Chief

September 6, 2000

The Honorable Ben Nighthorse Campbell
United States Senate
Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Attn: Aurene Martin, Majority Senior Counsel

Dear Ms. Martin:

The following are responses to your letter dated August 28, 2000, regarding additional questions on S. 2526:

1. In this bill is a provision dealing with something termed a "quip." Could you explain what a quip is and how it works?

Section 203. Qualified Indian Health Program (QIHP)

QIHP creates a new provider type for Medicare and Medicaid (M/M) and any other federally funded health care program. It allows for tribes to obtain full cost recovery from M/M for all services provided. Specifically, if M/M reimburses any other provider for the services, it must reimburse the tribal health program the cost of providing the services. It eliminates the problems (with respect to tribes only) which arise from the lack of authority for Medicare to pay IHS for physician services. it also allows the tribe to collect the full indirect rate from M/M.

QIHP also allows for 100% pass-through on some items which are currently only treated as pass-through for some states. It significantly broadens the wrap around services which must be covered under M/M, including outstationing, preventive primary health care, immunizations, and other services which have historically not been reimbursable.

In summary, QIHP allows tribes to be reimbursed at the actual cost of the service provided, rather than the discounted rate that is based on shifting cost to private insurance, when there is little private insurance in Indian health.

2. Why are the provisions of Title IV so important to tribes and Indian health care in general?

As you are aware, Indian health care in general is dramatically underfunded, as referenced in the Level of Need Funded Study. With Medicare, Medicaid, Children's Health Insurance Program, and private insurance currently only paying approximately 10% of all Indian health care services, all additional sources of revenue will benefit Indian people. Title IV would increase the percentage paid by these revenue sources only slightly, but any increase for Indian health care would enable tribes to provide care to even a few more tribal members.

3. You stated in your testimony that the Cherokee Nation operates six outpatient clinics that provide services to Medicare-eligible recipients, but is not able to get reimbursement from Medicare for those services. Could a non-Indian or non-IHS facility receive Medicare reimbursements for providing these same services?

Yes, a non-Indian facility could receive Medicare reimbursement if the individual has Medicare Part B. Most patients don't have Medicare Part B (which pays for outpatient services) so they utilize the Indian health care system instead of non-Indian health care facilities. Also, the Indian health care system receives 20% less than the non-Indian health care facilities because we don't receive the co-pay. Unless a tribally-operated clinic becomes a Rural Health Center, a Federally Qualified Health Center, or a Facility of the Service it cannot bill Medicare. This has become more problematic due to the phasing out of the full-cost reimbursements for Federally Qualified Health Centers.

4. As a tribal representative, can you tell me what you view as the most serious health problems facing Indian people in the immediate, medium, and long-terms?

As reflected in various data and numerous studies, diabetes and related conditions, such as heart disease, high blood pressure, and high cholesterol are the most serious health problem facing Indian people today. The complications of diabetes include amputations and blindness which render many American Indian's disabled. This is an immediate need that has not been adequately addressed.

Congress appropriated $30 million for 5 years to address this problem. However, as we are entering our 4th year, it is just not enough money to make a big difference in the diabetes epidemic. The Cherokee Nation received $1.37 million from the IHS Diabetes Grant Program for a 12-month period. One of the purposes of the 5-year Diabetes Grant program is to engage in tribally-directed prevention programs. However, the entire budget could be spent on drugs to treat people with diabetes, leaving no funding for other activities, such as nursing staff for diabetes clinics, orthotics, surgery, information systems, training and prevention.

Here at Cherokee Nation, unless we receive additional funding for diabetes, our entire Diabetes Grant could be consumed by paying for prescription drugs. There are three reasons for this: 1) the number of people diagnosed with diabetes is growing; 2) there are new and more effective drugs available to treat people with diabetes and they cost more than the older drugs; and 3) the IHS funding has not kept pace with the rising cost of pharmaceuticals.

Other serious health problems facing Indian people include cancer, alcoholism and other substance abuse related diseases, and serious and chronic mental illness, often resulting in suicide. A long-term health problem is disabilities from diabetes and from injuries due to alcohol-related events. Other long term health problems result from child abuse and domestic violence.

5. You stated approximately half of the enrolled tribal members in the U.S. live off the reservation. How many of these people live in urban areas? Do you support the IHS efforts to provide services for these tribal members in the Oklahoma City and Tulsa Urban Indian Health Centers?

Approximately 75-80% of the tribal members who live off the Cherokee Nation reservation live in urban areas.

Oklahoma City and Tulsa urban programs were designated as demonstration sites in the FY'87 Interior Appropriations Act. Since then, Congress provided further clarification on how the Oklahoma Demonstration Projects should be treated in the 1992 amendments to the IHCIA. The entire state of Oklahoma was designated a Contract Health Service Delivery Area (CHSDA) and urban Indian populations were included in the Oklahoma Area's calculation of IHS eligible patients.

P.L. 94-437, Section 512, passed in 1992, states that the "Oklahoma City Clinic demonstration project 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 for the term of such projects." This section also states that a report will be submitted to Congress for fiscal year 1999, which will include findings and conclusions.

The Tulsa Urban Indian Clinic is a beautiful and efficient clinic that serves the urban Indian people well. The clinic serves 140 tribes; with 45% being Cherokee and 26% being Creek. The clinic is the only urban program that is located within a tribal jurisdictional area.

Both Oklahoma demonstration projects are considered urban programs as well as service units. The ramifications of giving permanent status to these demonstration projects and

them retaining their Title V status as service units needs to be analyzed by the two tribes in this area.

The requirement for a report on this demonstration project should include a full analysis by the two tribes. Information is needed to determine the extent to which tribal funding is being used to support urban clinics in Oklahoma, and the sovereignty issues associated with tribal contracting and compacting of these service units.

The Cherokee Nation endorses the concept of federal funding for urban Indian clinics. However, the entire Indian health system requires adequate funding so that we are not competing for limited resources. With Oklahoma being the lowest funded area in the country, it is hard for us to endorse funding for other programs until the Level of Need Funded formula is implemented.

Thank you for this opportunity. If you need any further information, please feel free to contact me.

Sincerely,

Melissa McNiel
Executive Officer
Office of Principal Chief