S. HRG. 106–491, PT. 2

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

MAY 10, 2000
WASHINGTON, DC

PART 2

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REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, MAY 10, 2000

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

The committee met, pursuant to other business, at 10:02 a.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senator Campbell.

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

The CHAIRMAN. We will now move to the reauthorization of the Indian Health Care Improvement Act, S. 2526, which I introduced yesterday and was joined by the Vice Chairman and Senator McCain.

The current Indian health policy was presented in the 1970 Nixon Message to Congress on Indian Affairs, continued through the Indian Self-Determination and Self-Governance Act and is reaffirmed with the introduction of this legislation.

The legislation reaffirms the core principles that were part of the original act: that Federal health services are consistent with the unique Federal tribal relationship; that a goal of the United States is to provide the quantity and quality of services to raise the health status of Indian people; and that tribal participation in the planning and management of health services should be maximized.

Today we will discuss the first three titles of the bill. We will hear from panel 1, dealing with health service. Then we will continue with panel 2, which will focus on facilities construction.

[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

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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.
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"Sec. 224. Liability for payment.
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"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.
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"Sec. 309. Leases.
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"Sec. 311. Tribal leasing.
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"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.
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"Sec. 417. Waiver of medicare and medicaid sanctions.
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"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

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"Sec. 602. Automated management information system.
"Sec. 603. Authorization of appropriations.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

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"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.
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"Sec. 804. Availability of funds.
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"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;

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

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

"(d) ACTIVE DUTY OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

"(1) in the Indian Health Service;

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

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

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

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to

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)—

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

"(II) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training);

"(iii) to serve for a time period (referred to in this section as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary;

"(2) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under paragraph (1)(B)(iii);

"(3) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

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

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

"(g) LOAN REPAYMENTS.—

"(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

"(A) tuition expenses;

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.

"(l) BREACH OF CONTRACT.—

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

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

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

"(ii) voluntarily terminates such enrollment; or

"(iii) is dismissed from such educational institution before completion of such course of study; or

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

shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.

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

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

in which—

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

"(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

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

"(D) 's' is the number of months of such period served by such individual in accordance 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;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, shall establish an automated management information system for the Service.

"(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

"(A) a financial management system;

"(B) a patient care information system;

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;

1 "(B) costs for graduate medical education
2 programs;
3 "(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and
6 "(D) payment for outlier cases.
7 "(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment
9 for services provided under this section—
10 "(A) on the full cost recovery basis provided in paragraphs (1) through (5);
12 "(B) on the basis of the inpatient or outpatient encounter rates established for Indian
14 Health Service facilities and published annually
15 in the Federal Register;
16 "(C) on the same basis as other providers
17 are reimbursed under this title, provided that
18 the amounts determined under paragraph
19 (c)(2)(B) shall be added to any such amount;
20 "(D) on the basis of any other rate or
21 methodology applicable to the Indian Health
22 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.

"(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

"(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

"(2) under an agreement entered into under subsection (a) between the entity and the Secretary.".

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101–630 (25 U.S.C. 1653 note) is repealed.

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. We will start with panel 1 which will be Taylor McKenzie, M.D., the vice president of the Navajo Nation; Julia Davis, member, National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. She holds the chair of the Northwest Portland Area Indian Health Board; Yvette Roubideaux, M.D., president, Association of American Indian Physicians; and Barbara Dahlen, the assistant coordinator of the Recruitment and Retention of American Indians into Nursing.

With that, I would welcome you to the committee. Why don't we just go ahead in the order we announced with Dr. McKenzie starting first?

STATEMENT OF TAYLOR McKENZIE, VICE PRESIDENT, NAVAJO NATION, WINDOW ROCK, AZ

The CHAIRMAN. Since we got off to an awful late start since we had a vote, your full written testimony will be included in the record. If you could be concise and abbreviate a little bit, the committee would appreciate that. Dr. McKenzie.

Mr. MCKENZIE. Honorable Chairman Campbell and Honorable Senator Inouye, and members of the Senate Committee on Indian Affairs, my name is Taylor McKenzie, vice president of the Navajo Nation.

I am here today on behalf of the Navajo Nation to testify in support of the Indian Health Care Improvement Act, Public Law 94–437. The legislation I am testifying on today is the result of many regional meetings between tribes, tribal organizations and urban Indian organizations.

These meetings gave rise to the National Public Law 94–437 Steering Committee. I had the honor of serving as chair for titles I, II, V, and VII. The Navajo Nation strongly and fully supports this legislation because it represents the collaboration of Native Americans working with the Indian Health Service to draft legislation that is truly representative of the needs and preferences of Indian people.

I would like to highlight some key areas regarding the preamble of 3397 on which we worked on titles I, II and III.

I respectfully request that members of this committee review and accept the Navajo Nation's written testimony which is appended and presented today.

The preamble was revised to reflect the trust responsibility of the Federal Government to fund and deliver health care to Americans and Alaska Natives. The Navajo Nation supports this reaffirmation of the special relationship between tribes and the Federal Government and urges the Federal Government to act with diligence to eliminate disparities between Indian programs and those of the U.S. population.

America's native population will benefit greatly from the amendment citing "Healthy People 2000" as the goal for Indian health care to be met by 2010.

The Navajo Nation is extremely pleased with the preamble's provision that requires Congress engage in consultation with Indian tribes, tribal organizations and urban Indian organizations.

We also favor the provision stating the funding for Indian health programs run by entities other than the Indian Health Service not be less than those run by the Indian Health Service.

The Navajo Nation strongly and fully supports more autonomy for local service areas under title I. Title I requires consultation with tribes, tribal organizations and urban Indian organizations in addressing human resource development and funding.

Indian Health Service scholarship recipients must meet service obligations in the areas awarding the scholarships and this will mean that traditionally underserved areas will benefit from medical professionals recruited by and provided to their own areas.

Title II eliminates the list of distinctive service and programs and expands on the programs offered Indian Health Service patients, including traditional healing practices.

The Navajo Nation supports this title along with the revision that provides for tribal input in programs devoted to preventive education and healthy lifestyle promotion. The Navajo Nation is also in favor of expanding diabetes and dialysis programs with permanent funding to counter the staggering rates of diabetes in Indian country. This is epidemic.

Environmental factors that affect Navajos are an important priority to the Navajo Nation. We support provisions to study and monitor programs that address the health issues of Indian minors and Indian communities that reside in environments that pose health hazards resulting in chronic and life-threatening ailments.

Tribal consultation and the establishment of health care facilities serving Indians is a vital component of self-determination.

The Navajo Nation supports title III, the assertion that tribes must be consulted in the establishment of the health care priority system and for the construction, renovation or closure of any IHS facility. We emphatically urge Congress to appropriate the necessary funding to replace or renovate health care facilities and to construct additional facilities and staff housing.

We also recognize the critical need for proper water and sanitation systems to promote better hygiene and health in the homes of Native Americans and Alaskan Natives.

In closing, the Navajo Nation believes that the current draft of the proposed amendment for the reauthorization of the Indian Health Care Improvement Act will significantly improve the quality of health services to native Americans and that it will improve the overall health of Indian and Alaskan Native people.

We respectfully urge this committee to assist in moving the proposed Public Law 94–437 legislation through the U.S. Congress. Thank you for allowing me to testify on behalf of the Navajo Nation.

[Prepared statement of Mr. McKenzie appears in appendix.]

The CHAIRMAN. Thank you, Dr. McKenzie.

Ms. Davis.

STATEMENT OF JULIA DAVIS, MEMBER, NATIONAL STEERING COMMITTEE ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT; CHAIR, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, PORTLAND, OR

Ms. DAVIS. Good morning, Chairman Campbell.

The CHAIRMAN. Are you shy?

Ms. DAVIS. You will have to excuse my voice. I have a cold.

The CHAIRMAN. There's a doctor sitting next to you if you want to ask for some advice. You are in good company there.

Ms. DAVIS. It is a pleasure to see you this morning and talk with you about the Indian Health Care Improvement Act. We were very pleased to see that this hearing took place.

As vice chair of the National Indian Health Board and chair of the Northwest Portland Area Indian Health Board, we were constantly writing and calling and asking the Senate Committee on Indian Affairs to have a hearing on this. So we do appreciate your effort to do this.

As was mentioned earlier, the draft bill is Senate version of the consensus bill that was developed by the tribes and this took place from May last year to October of this year.

We had a lot of work that took place in those work groups. What I am going to speak about to you today is the title III section which deal with facilities construction. I was cochair of that work group and I am pleased to report to this committee that we had a cooperative spirit of all the people that were involved in working on that section.

I think it is a strong section that, if passed as proposed, would vastly improve the sorry condition of the facility's infrastructure of Indian health programs.

Before I go over the proposed changes, I would like to just say a few words about Federal funding for health facilities.

Medicare and Medicaid provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare and Medicaid program.

Yet, American seniors receive care in the most modern clinics and hospitals in the world. Indeed, it is remarkable but true that poor Americans who are eligible for Medicaid in Washington, Oregon and Idaho now receive their care in the same facilities as other non-poor Americans. That's right, in the same very clinics and hospitals that are the envy of the world.

What about the Indian people? Their clinics, with notable exceptions, are old, on average more than 30 years old. My clinic in Lapway, ID is 40 years old. The clinic director has her office in a window-less office basement room.

Often, when one of our tribal members becomes eligible for Medicaid they chose to drive 20 miles to the border town to see a doctor in a modern facility and not at our clinic. The clinics are not just old, they are inadequate.

What explains the poor condition of so many Indian clinics? Unfortunately, it is the budget process itself that annually underfunds the Indian Health Service budget that is the cause of the poor condition of our facilities.

There is no doubt that again this year no progress will be made to address the backlog of facilities need. This choice is unfair. No one asks Medicare recipients if they want facilities or programs. They get both.

It is bad health care and bad business to have poor facilities. Because the Indian Health Service is a discretionary program, our funding is limited and proposals for facilities construction are the low-hanging fruit that is chopped off every year. In fact, I think it is wrong that we don't ask for more than we do each year.

I think that the proposed title III section has widespread support. In the Northwest we have presented the title to our board and at two special meetings in December and April, I can report to you that our tribes have not expressed any serious reservations on title III.

However, I would understand if some tribes would like to have more time to fully understand this section of the bill. I am happy to present this testimony and I will answer questions. Thank you.

[Prepared statement of Ms. Davis appears in appendix.]

The CHAIRMAN. Before we go on to Dr. Roubideaux, I might tell you Julia that this is not the first hearing. This is the second of three. We did one already. We are doing this one. We will be doing another one in July.

If you have been contacting the Indian affairs office, as you said you have a number of times, the staff is right here. It is not like this thing just started today. It has been going on. I would have thought that most people in the Indian communities would have been aware of it. This is a series of hearings.

In any event, I have to also say that one of the problems Indian people face around here, and as you probably know, this is a body that reacts to pressure and suggestions and all kinds of things.

When you mentioned the facilities that seniors get, AARP has about 4 million members and they know how to bring a lot of pressure on this body, as you probably know. One of the problems I think we have always faced is that Indian people tend to be often very stoic. They don't say anything. They sort of just take it.

They shouldn't. They need to get more involved. They need to be here to tell us what they want and what we need to do. So let that be a lesson when it comes time to participate in the process, to vote, and to call your Representative and so on to make your voice heard.

Dr. Roubideaux, go ahead.

STATEMENT OF YVETTE ROUBIDEAUX, M.D., PRESIDENT, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, OKLAHOMA CITY, OK

Ms. ROUBIDEAUX. Good morning, Mr. Chairman. My name is Yvette Roubideaux and I am the president of the Association of American Indian Physicians. I am a member of the Rosebud Sioux Tribe. I am a Harvard-trained, board certified internist with experience working in the Indian health system.

On behalf of the Association of American Indian Physicians, I would like to thank you for the opportunity to provide testimony and support for the reauthorization of the Indian Health Care Improvement Act.

I believe the Association of American Indian Physicians is now beginning to realize its role as a leader in improving the health of Indian communities.

We are a national nonprofit organization that was founded in 1971 by 13 Indian physicians. We now have approximately 300 Indian physician members. Many of our members have seen firsthand the health problems and challenges in Indian communities and the pressing need for more resources in all area of Indian health.

Despite being trained at the best medical school and residency program in the country, I faced significant sadness and frustration at the lack of resources, outdated equipment and facilities and shortages of high quality health care providers and staff.

Sadly, American Indians are also the most under-represented minority in the physician category compared to the general population.

We support the reauthorization of the Indian Health Care Improvement Act and its reaffirmation of the Federal trust responsibility and the sovereign rights of tribes to self-determination and self-governance

We also believe that Indian people deserve to have the opportunity to receive medical care from well-trained, culturally competent, American Indian and Alaska Native health professionals.

The major focus of our testimony today will be on title I, the Indian Health Resources and Development. We are grateful for the Indian Health Service Scholarship Program. I would not be sitting here today as a physician without the support that I received under sections 103 and 104.

However, while we agree that the scholarship program should be more responsive to local priorities and needs, we are not supportive of further restrictions on the location of pay-back obligations for the scholarship recipients to the area from which they received their scholarship funding. Placing more restrictions on pay-back options will further demoralize these individuals, worsen efforts at recruitment and retention and potentially result in placement in positions that do not match qualifications or career needs.

We strongly recommend that the current rules for pay-back should be retained and language that restricts pay-back to a specific area should be eliminated. The language that says "for special circumstances, a recipient may be placed in a different service area" is not strong enough and does not guarantee appropriate placement for these recipients.

We have also commented on the other titles in our written testimony. In title II, section 204, we support continued funding of the current model diabetes programs and programs funded under the Special Grants for Diabetes Program created under the Balanced Budget Act of 1997.

Funding for these diabetes programs must be continued through 2012 as the problem of diabetes in American Indian communities is reaching epidemic proportions and more resources and programs are needed to fight this growing problem.

In addition, we support retaining language to fund at least one area diabetes consultant for each service area and disagree with the current language to retain these positions at the discretion of each area.

We support all provisions in title III that would allow the construction of the high quality state of the art health care facilities for all Indian communities as soon as possible.

We strongly agree with the recommendation in title XI that the director of Indian Health Service should be elevated to an assistant secretary for Indian health.

We also strongly recommend that the position of the director of the Indian Health Service should continue to be filled by an American Indian or an Alaska Native physician.

On behalf of the Association of American Indian Physicians, I would like to thank the Senate Committee on Indian Affairs for the opportunity to provide testimony at today's hearing and to offer our organization as a resource to the Senate committee and the tribes and the Indian organizations involved in this process.

We encourage your efforts to help us achieve reauthorization as soon as possible. Thank you.

[Prepared statement of Ms. Roubideaux appears in appendix.]

The CHAIRMAN. Thank you. We appreciate that.

Ms. Dahlen.

STATEMENT OF BARBARA DAHLEN, ASSISTANT COORDINATOR OF THE RECRUITMENT AND RETENTION OF AMERICAN INDIANS INTO NURSING [RAIN], UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, ND

Ms. DAHLEN. Good morning, Mr. Chairman. It is an honor and a privilege to be here today to speak on behalf of the Quentin N. Burdick Indian Health Programs.

As you know, the Quentin N. Burdick programs come under the Indian Health Care Improvement Act. They are housed within the act. The Quentin N. Burdick programs contain the RAIN program, Retention of American Indians into Nursing, INMED, Indians into Medicine, and the INPSYDE Program, Indians into Psychology.

These programs are housed at the University of North Dakota and have been proven to be very successful in educating and retaining American Indians and increasing the number of health care professionals who return to Indian country.

The INMED program has graduated 122 graduates which consists of one-fifth of all of the American Indian doctors who work in the Nation.

The RAIN program, prior to 1990, had graduated 18 American Indian nurses. When you look at the College of Nursing itself that opened in 1948, so from 1948 to 1990, they could only boast 18 graduates. Since 1990, in the 10 years that the RAIN Program has existed, we have graduated 70 American Indian men and women with their Bachelors in Nursing. Since 1995, we have graduated 16 men and women with their Master's Degrees.

In that short span you can see the impact that the RAIN program has had, not only on the recruitment, retention, but also the graduation rate of American Indians who come to the University of North Dakota.

We have been recognized as a national model and now are internationally recognized as a model program for the Nation. We have been visited by the University of Australia School of Medicine. We have been visited by New Zealand for the Maori people to emulate

our program, to find out what we have done right and why we are retaining people the way we are and why people are coming to the University of North Dakota.

What I can say is that retention is labor intensive, it is a 24-hour job and it is the commitment. We have had the honor and privilege of working with the Indian Health Service and under the Indian Health Care Improvement Act.

We have formed partnerships with tribal colleges. In the past, when students would fail they would fail or drop out. They would just stop out. There wouldn't be any track record of what happened to that student, what went wrong, why did they leave the university. We track all those things.

In partnering with the Sisseton Wahpeton 2-year tribal program, instead of losing students for whatever reason we find that students sometimes need the ladder approach to success, so we send them into the 2-year RN program at Sisseton Wahpeton and they receive their 2-year degree. We track them to come back into the RN/BSN option track.

Without those efforts, without those partnerships, without going to the tribal colleges at Fort Berthold, at Fort Totten, at Fort Peck, we have indeed increased their pre-nursing curriculum and worked with those faculties at the tribal college level to say, you can prepare them in the pre-nursing arena for them to come to us indeed much better prepared.

When we start looking at retention efforts, we looked at conceptual frameworks that would help us. What we found out was that prior schooling, prior family background all impacted retention.

So, with these efforts we found that we had to look at our students in a whole different light.

We thank you for this opportunity. Again, it has been an honor and a privilege to speak before you, Senator Campbell.

We hope that our efforts will be continued with the ever increasingly shrinking dollars that we are working with. Thank you.

[Prepared statement of Ms. Dahlen appears in appendix.]

The CHAIRMAN. I thank you. Let me ask each of you a couple of questions.

Dr. McKenzie, we are a little bit confused about the designation of Arizona as a contract delivery system. Most of the Navajo people are in New Mexico or that proximity; are they not?

Mr. MCKENZIE. We have many Navajos in the metropolitan areas. Most of them still reside on the reservation.

The CHAIRMAN. More have gone to Phoenix than, say, Albuquerque?

Mr. MCKENZIE. I would say probably more in Phoenix, yes.

The CHAIRMAN. The Navajos who live off reservations, that are in urban areas like Phoenix, where do they get health services now? Do they usually come home?

Mr. MCKENZIE. There are several ways that they seek out health services. One, yes, is to come home and to use the Indian Health Service facilities.

In those cases where they made contact with the home health program, if they should encounter an emergency situation they would be eligible for contract health services from the home area,

but there has to be a well-defined relationship between that urban individual and the home base.

Then there are those that are eligible for the various health programs that the State provides and they are eligible to apply for that. Many of them do use the Medicare/Medicaid and children's health programs the States provide.

The CHAIRMAN. Those are open to everybody?

Mr. MCKENZIE. Those are open to everybody, yes.

The CHAIRMAN. Does Arizona have health care programs through the State that are specifically designed for urban Indian people?

Mr. MCKENZIE. No.

The CHAIRMAN. They do not.

Ms. Davis, speaking about urban Indian people, there is a bigger increase of Indian people going to the city. They need jobs, so they migrate to the city. I was interested in your view on the proposed definition, the new definition of Indian in the bill.

We have always had a problem with that, as you know. We deal with it in arts and crafts and medical services and everything you can think of. Would this have an effect on the number of people that get help in urban areas? How would you define who should avail themselves to those services? Is it just being enrolled or what?

I mean, you know, we have blue-eyes blondes that are 1/160th, but legally they are Indians because of the lineal decendency that some tribes use. I remember one bill years ago where a person was 100 percent Indian, but he was eight-eights so he was not on anybody's roll.

So, legally, according to the Government definition of who is an Indian, he was an Indian but, you know, every one of those tribes had a one-fourth or more provable ancestry requirement.

Ms. DAHLEN. Chairman Campbell, I am so glad that you asked that question, for the fact that the Indian Health Care Improvement Act Committee, the leadership committee, had a lot of discussion on entitlement.

One of the proposals that we have in the Indian Health Care Improvement Act is to form an entitlement study commission to look at that very issue on eligibility.

We knew that it would be a hard decision, that it would be hard because each tribe has their own enrollment and their own eligibility and we would be stepping on toes, but we really felt strongly that we needed to address it.

So that is one of the recommendations.

The CHAIRMAN. I think it is a good idea. I don't know, it may come in conflict with what some tribes see as tribal sovereignty, but it might be a difficult thing to do.

I remember one man who testified on a bill. He was Hopi on his dad's side. Apparently, in the Hopi roll, you can only be enrolled if the ancestry comes from your mother's side. It is a matriarchal society. So you could be the same amount of Indian, but depending on which parent was enrolled, you might or might not be able to get on the Hopi roles. I think it could create a problem on this, too.

You also had some views on cultural training. Title I of this bill requires that appropriate employees receive instruction in the cul-

ture and history of tribes. I think that is really important for those tribes that have very strong traditions.

I know I have had Navajo friends tell me that their spiritual leaders often work with the medical profession in trying to diagnose or trying to help people. I have seen that with other tribes, too.

My question would be, who is deemed appropriate? I recognize that there is some importance, but how do you define who is appropriate? Is it tribe to tribe to determine that? Who within the tribe determines it?

Ms. DAVIS. The traditional healer?

The CHAIRMAN. Yes; if they are going to be appropriate employees who receive instruction in culture and history——

Ms. DAVIS. Okay. What we have done, and I will give you an example from our tribe, what we do is like cultural sensitivity training. We have people that come from back east, back here as a matter of fact. They come out there and they have no idea. They still think that the native people live in tipis, that they still run around with their horses and things.

So, we do have to have cultural sensitivity training for them and explain to them the traditions and the heritage of our tribe. I know that other tribes do that, too, but it is really needed, really bad.

The CHAIRMAN. This has nothing to do with that, but years ago I was up home visiting where I am enrolled in the Northern Cheyenne. At a little gas station a carload of tourists came through and they must have been out of gas or something. They pulled up at the gas station and the guy driving rolled down the window just a little crack. He said, "fill it up" and rolled the window back up real fast. I got the impression that he had been watching too many 1930's movies.

Traditional healing practice as discussed in title II would be integrated into modern health services. I would assume that those healing practices would be intended not to replace medical services, but to advise and try and coordinate traditional beliefs. Is that your view?

Ms. DAVIS. Yes; we did talk about it in our leadership group. We felt that traditional healing was very, very important for all of our native people. I know that Dr. McKenzie has some other important information on that.

The CHAIRMAN. Would you like to add to that, Doctor?

Mr. MCKENZIE. Thank you, Julia. Senator Campbell, I appreciate the opportunity to respond to that. Traditional healing is very much a part of the health care system of the Navajo people.

I have had an opportunity to kind of take a look at the two health care systems side by side and they are very similar. I think that perhaps maybe it is the logic of the thinking that makes them very similar in their approach.

So, I consider the traditional healing practices a science because it fits that description So, it should be very much a part of the health care system, even to have it available within the inpatient facilities as well as the outpatient facilities.

Some of our facilities do have an office for traditional health care practitioners to advise patients as they come to the clinics and should be very much a part of the health care system.

The CHAIRMAN. Do you find in the Navajo culture that the elderly people believe or rely more on the traditional methods than, say, the young teenagers within the tribe?

Mr. MCKENZIE. They are not rigid like that. There are cross-referrals. When a traditional healer feels that he has encountered something that is not amenable to native healing practice solutions, he will refer that patient to a western practitioner and vice versa.

The CHAIRMAN. I see. Thank you.

Maybe one last question to Julia. We have to be able to pay for things around here, as you know, Julia. We are always looking for some creative ways to find the money. If we have a revolving loan fund, do you have a ballpark figure on what we are going to need to get this program going? Have you done any study of that in your group?

Ms. DAVIS. Just off the top of my head, one of the figures that we were thinking about to at least get us started was like $100 million for facilities, because there is such a need, Chairman Campbell, for facilities.

I know that you do travel across Indian country, but the clinics, if you would go there, some of them are just trailer houses and old facilities that have not been upgraded.

The CHAIRMAN. Yes; I visited some. Even when we get a new building occasionally putting the facilities in the building is a whole other structure. The building in and of itself doesn't heal anybody. You have to have the equipment and the knowledge and so on. All right. Thank you.

Dr. Roubideaux, for my own information, how many Indian physicians are there now in your association? What percent do you think got their medical training through some form of scholarship?

Ms. ROUBIDEAUX. There are currently about 300 members of the Association of American Indian Physicians. I would have to estimate about one-third of them got the Indian Health Service Scholarship.

The CHAIRMAN. Were you raised at Rosebud?

Ms. ROUBIDEAUX. I was raised in Rapid City, SD.

The CHAIRMAN. Rapid City?

Ms. ROUBIDEAUX. My father is from the Rosebud Reservation and my mother is from the Standing Rock Reservation.

The CHAIRMAN. As I understood your testimony, I was trying to jot some notes here, and you apparently don't particularly support the payback restrictions; is that true?

Ms. ROUBIDEAUX. Yes.

The CHAIRMAN. I don't know how we are going to deal with that. Let me just put it this way: If you go in the military and you want to be a doctor, you have no money but you want to be a medical doctor, you can go to the military, for instance, if you get through an academy and they will actually send you to medical school, as you probably know, after you graduate West Point or one of the academies.

But they will only do it, because they are going to have a terrific investment in you as a young military person, so you have to sign an agreement saying that you will give them so many years back for the training and the money that they put into you.

It would seem to me that doctors, I don't know for sure, but I heard Ms. Dahlen's testimony about the number of nurses that go back to Indian country. She said something like 90 percent, which I think is great.

Do you know what percent of Indian people who get their medical degree go back to Indian country as opposed to the ones that move to the city where there is better money and, you know, let's face it, we all have to make a living.

Ms. ROUBIDEAUX. Right. A significant number of our members worked in the Indian Health System or tribal urban programs at some time in their career. For example, of the current 300 members, 200 members, in a recent survey, said that they worked in the Indian Health System at some time.

Currently, however, only 69 of our members work in the Indian Health System.

The CHAIRMAN. Well, to me that is a way of paying but. But that is voluntary. They decided to do that themselves, which is good. But you are really opposed to a requirement that they do it?

Ms. ROUBIDEAUX. No; I don't' want you to misunderstand, Mr. Chairman. I am supportive of, if a physician signs a contract, they need to pay back that scholarship in the Indian Health System.

However, in the bill the language has been changed so that they have to pay it back in the specific area where they got the scholarship. I think that is too restrictive.

The CHAIRMAN. Yes; I see.

Ms. ROUBIDEAUX. I think that is too restrictive. When I was a scholarship recipient, I got my funding through the Aberdeen area, but when I graduated my residency, there were no suitable positions for my training in the Aberdeen area. I was trained as an internist and I would have had to do things outside of my specialty if I had to go to the Aberdeen area.

Fortunately, there was a wonderful position in the San Carlos Apache Reservation where I was able to use my skills, both in internal medicine and in administration and management and it was a wonderful opportunity. So, I am just asking for some flexibility.

The CHAIRMAN. So, that requirement would hinder physicians from going on to further training because they might be in an area where there just isn't any opportunity for them to specialize.

Ms. ROUBIDEAUX. It may hinder further training, but it also will hinder their ability to practice their specialty. A pediatrician may be sent somewhere to be a family doctor. I don't think it is right for pediatricians to be seeing adults if they are not trained to do that.

So, I believe there should be as much flexibility as there currently is in the Indian Health Service scholarship program where you pay back in an area of need where there is an opening, anywhere in the country. It is up to the areas to recruit the doctors that they need and to attract them to come to those areas.

The CHAIRMAN. Well, I guess Indian country is like a lot of non-Indian country and that is small, rural areas, farm towns, for example, have much more difficulty recruiting physicians as you know.

I would guess that Pine Ridge has more difficulty than a reservation that is next to a big city as an example. We need to find a way

that we can encourage people to go to places that might not be their first choice.

Ms. ROUBIDEAUX. Absolutely. I think if there were some provisions in title I that supported recruitment and retention efforts at some of the higher need facilities, for example recruitment and retention bonuses, and made that process a very easy process, then you would get more physicians choosing to go in the highest need areas.

The CHAIRMAN. Thank you.

Ms. Dahlen, you have a total of 43 students currently enrolled; is that what I understood you to say?

Ms. DAHLEN. That is right, correct. They are currently enrolled at this time.

The CHAIRMAN. I am interested in the tribal colleges, partly because I am on the American Indian College Fund board and help with them.

It sounds like you had some very good collaboration. Can you explain just very quickly how the programs are integrated with the university to successfully train health care professionals?

Ms. DAHLEN. How the tribal programs are?

The CHAIRMAN. Yes.

Ms. DAHLEN. For instance, we have worked extensively with Belcourt in order to create a pre-nursing curriculum so that as the students who identify their choice of nursing as a career option can go to the Turtle Mountain Community College or the Fort Totten——

The CHAIRMAN. You try to get it accredited?

Ms. DAHLEN. We try to get the curriculum so that all the credits are transferable so that teachers who are teaching it have the credentials to teach it.

The State Board of Nursing requires certain classes be taught by Master-prepared nurses. So we bring all that information to them. We bring curriculum. I, myself, look at the curriculum.

I sit on the Curriculum Committee in the College of Nursing so I can look at the Tribal College curriculum and I can look at our curriculum and I can say to them, "This course is strong enough. It will come in" or "This course is very strong in this area but perhaps weak in this area. If you strengthen it, we have a change of getting it in and getting it transferred."

By doing that at Totten, at Belcourt, at Fort Peck, they all have very strong pre-nursing curriculums. The tribal college at Sisseton Wahpeton has an excellent 2-year RN program where we are now sending students, like I said, to transfer into that program if we find they are not going to make it at the 4-year level initially. It gives them a starting point.

Fort Berthold has a 2-year LPN program. When we went to Fort Berthold they had a very high failure rate on their boards for NCLEX examination of their nurses. With working with them and developing a preparatory program for them to prepare them for boards, they are up in the 90 percentile for board pass. On the NCLEX examination, all of our students have passed their boards and are working.

When I say 90 percent of our nurses have remained in Indian country, that is 90 percent after obligation is fulfilled. Nurses stay.

We have tracked both physicians and nurses and we have looked statistically at who stays in Indian country, it is the nurses who stay the longest.

That is why the need for nurse-practitioners and funding for nurse-practitioners and nurse-midwives is so important, because they stay so long. They do their obligation and they go back home and they are wives and mothers, and yet we have those long-term commitments.

The CHAIRMAN. We would have you give the secrets of your success to Dr. Roubideaux and the physicians, too.

I thank this panel very much for appearing this morning. Thank you.

We will now move to panel 2, Jerry Danforth, chairman of the Oneida Tribe of Indians of Wisconsin, and Douglas Eby, M.D., the vice president of Medical Services for the Southcentral Foundation from Anchorage, AK.

We will go ahead and start with Jerry Danforth please, and then we will proceed with Dr. Eby.

Mr. Danforth, please go ahead.

STATEMENT OF GERALD DANFORTH, CHAIRMAN, ONEIDA TRIBE OF INDIANS OF WISCONSIN, ONEIDA, WI

Mr. DANFORTH. Chairman Campbell, members of the committee, good morning. My name is Gerald Danforth. I am the chairman for the Oneida Tribe of Indians of Wisconsin, representing about 14,000 members.

I thank you for this opportunity to appear before you today. I would like to discuss two points: First the Oneida's participation as one of the delegates to the National 437 Steering Committee. As a participant on the steering committee, the Oneida Tribe took great interest in contributing to the redrafting of title III, Health Facilities, and title IV, Health Care Financing.

Second, I would like to take the opportunity to address the current shortfall in funding for new health facilities, its impact on the health of Oneida members, and a proposed innovative solution to that problem.

In June 1999, the Indian Health Service convened a National Steering Committee made up of IHS, Indian governments, and urban Indian organizations. The initial plan for that steering committee was to develop broad concepts and general ideals for the distribution of Federal funds for Indian health.

After the initial meeting, however, that steering committee decided to tackle redrafting in a comprehensive way, the Indian Health Care Improvement Act. That was based on consensus recommendations developed at four regional consultation meetings.

The final proposed bill was presented in October 1999 to the Director of Indian Health Services and to each authorizing committee in the House and Senate.

The Steering Committee allowed the Indian Nations of the United States, including the Oneida Tribe, to have a powerful voice in that amendment and renewal of preeminent Indian health care law.

The Oneida Tribe fully supported and continues to support Indian Health Care and the Improvement Act Reauthorization

Amendments as the most feasible solution for the advancement of Indian health.

With regard to my second point regarding construction of new health care facilities, we are strongly in support of the reauthorization of the Joint-Venture Program. Under this program, tribes will be able to finance construction of adequate facilities if His will equip and staff the facility.

The Oneida Tribe, along with other members of the tribal nations Joint-Venture Coalition are working to develop and construct facilities with funds that they would generate by bonding or through promissory notes.

If IHS were to assume the cost associated with equipping and staffing these facilities, it would be possible to construct appropriately sized and equipped facilities to provide adequate health services. Such funding is already authorized in law as the Joint-Venture Demonstration Program. The proposed amendments shorten the no-cost lease to the IHS provisions in the joint venture.

With adequate funding for the joint venture program, three or four tribes annually could complete the construction of their facilities, putting them up to 60 years ahead of schedule. I come up with that because under the current need there is a need for $938 million for new construction of health facilities in Indian country.

In considering the current funding levels, those tribes who have managed to secure a spot on the very exclusive IHS health construction priority list could have up to a 60-year wait for that facility to be built.

As a consequence, the existing health facilities are outdated, difficult to maintain, inadequate, and in desperate need of replacement.

In Oneida, our health department struggle to meet the demands of an increasing population of aging, of an aging building that is far outdated, we have three trailers currently that are placed on our property to provide our health care needs to the citizens of our community.

Our patient rate is growing. It has increased over 9 percent over the past 7 or 8 years. We have a growth in our departments and our enterprises and businesses and programs that we have on the reservation. As a result, we have a number of members moving back to the reservation. So, our population has grown immensely in the last 10 years and is projected to continue that growth in the immediate years and the projected long-range growth as well.

The bottomline on the Joint-Venture, we see the Joint-Venture Program as the needed booster shot to take us over the hump, and in the out-years we envision the possibility of even third-party billing to be able to become completely self-sustaining through this program.

But in order to get there, this Joint-Venture Plan would be the necessary means to achieve that goal. So the Oneida Tribe strongly encourages you to support the funding for the Joint-Venture Program. We also ask that you encourage your colleagues on the Appropriations Committee to do the same.

Thank you very much for your time and attention on this matter.

[Prepared statement of Mr. Danforth appears in appendix.]

The CHAIRMAN. Go ahead, Dr. Eby.

STATEMENT OF DOUGLAS EBY, M.D., VICE PRESIDENT OF MEDICAL SERVICES, SOUTHCENTRAL FOUNDATION, ANCHORAGE, AK

Mr. EBY. It is an honor to be here today. I am also honored by your correct pronunciation of my name as you did. Only having three letters, it is pronounced many different ways.

I come as vice president of a native-owned private corporation that is located in Alaska, in Anchorage, in the land of the Denina. I come to you on behalf of the Southcentral Foundation Board, our president/CEO, Katherine Gottlieb, the corporate vice presidents and the staff of the corporation.

My goal is to give you a real life example of what we have been able to do under native ownership and native management, and not really speak to the general provisions of the Health Care Act.

In Alaska, the entire State, the large Indian Health Service-run program in the State of Alaska is now completely native-owned and completely native-managed. Some people are very proud of this. This allows us to be more locally focused and more culturally appropriate. It allows us to get at issues of respect and dignity and to decrease issues of dependence in the Alaska Native community.

It has increased our ability to partner with other organizations since we are no longer a Federal agency. It has allowed us to combine funding sources and to pursue other funding sources such as contracts, grants, and so forth and extend the moneys that we are given through the Indian Health Service funding stream.

Some of the examples of what we have been able to do despite providing service to 350,000 outpatient visits in the last year and despite having relatively inadequate funding, we have been able to do some exciting things. We would invite you and anyone else who wishes to come visit us.

Right now you can choose your own primary care provider. We guarantee you seeing that primary care provider today for anything you want to see that primary care provider for; today, in the way you want to see them, in the way you want the information, whether it be by phone or in person or in a group setting or through a case manager.

We do everything we can to connect the same primary care provider and the patient over time. We have been able to increase by three-fold the connectivity of the patient and the primary care provider and we have decreased our no-show rates from 25 percent down to below 5 percent.

What we have done is follow Native leadership, native management and the customer. As a customer-owned system of care, we are constantly talking to the customer and changing our system to be in the way that our customers want it to be.

Part of the way we have done this is an unyielding access priority. If you build a good system and the people can't get in, it is not worth anything. So, access is our primary cornerstone.

The other thing is, the people who come to our services come for their life and often for generations. So we build a very relationship based system where you see the same provider, where you get consistent messages, where you work in partnership on the ability to learn and to do more self-care become a central priority of the sys-

tem, again increasing issues of respect and dignity and decreasing issues of dependence.

We have mandated population-based thinking in our clinics. Part of the other thing that we have done is what some of the other people have spoken to today, is Native development, Native professional development and we have moved now native managers into day-to-day management of every single clinical program we have.

When we took over the system at Alaska Native Medical Center, the portion of it we have, 2 years ago there were hardly any native managers. We now have 35 native managers in the pipeline coming up through the stream.

Despite decades of management, the Alaska Native Medical Center, as it is transitioning right now at the senior positions there is a paucity of eligible, qualified, and experienced native managers. This is something that has got to change.

When you put the system into customer-owner hands, you start to get that priority because it is a very strong priority in the native community.

Facilities is another things that we see as important. We have done very many creative things partnering with our for-profit corporate partners and other people in the community to try to find those precious facility dollars.

There are a lot of things Indian Health Service does not provide funding for and has not provided structural support for that our native leadership feel is important. Service to adolescents, Anchorage is a fairly urban environment.

The statistics around the transition from school to adult life in the native adolescent population, the statistics are abysmal and it is a focused, targeted area that our native leadership have said they want to focus on, but it is not something that there has been any attention to in the Indian Health Service funding stream or structures that we have inherited.

Another issue is elders and long-term. Another priority for our board is hospice care, allowing native people to spend their last months or year with their family in the way they want to, again, something that has not been a part of the historical IHS funding stream.

So, as we have moved to native management we have done a lot of things. We are building toward long, term sustainability. We have found ways to be much more efficient.

Utilization rates are dropping while no-show rates are dropping. But our effectiveness is going up and our patient satisfaction and provider satisfaction are climbing rapidly as well.

It is a system that builds on the strength of all of the different pieces and allows us to get to issues of prevention and wellness in effective ways. It is culturally appropriate. It is native-run. We have mandated training for all of our staff on natives.

It is increasing dignity and respect while decreasing issues of dependency in the community. We come as strong supporters of native self-determination, the transition to Native management and the support of the Indian Health Care Reauthorization Act as one of the tools to get there.

We feel strongly that native management can do it and has a strong, proven track record in areas where there has been the possibility of doing so.

Thank you for your time.

The CHAIRMAN. Yes; thank you. Let me ask you a couple of things, Dr. Eby. I have been to Alaska a number of times with Senator Stevens and Senator Murkowski. It is a beautiful State, but it does have huge distances, some weather variance. The last time I was in Barrow, it was 42 degrees below zero. You certainly have some transportation problems.

You talked in your testimony about same day service. Given those limitations, how does the Southcentral Foundation manage to do that?

Mr. EBY. Southcentral Foundation provides primary care services to the urban population of about 30,000.

The CHAIRMAN. Is that primarily around Anchorage?

Mr. EBY. Then there is another 12,000 that are village based. For the village-based population there is the health aid system which you may be somewhat aware of. Part of what we are doing right now is putting more and more technology in their hands so that we can actually see pictures and have more real live interaction.

The other things we have done is create a Native Advisory Board for those villages that give us advice and tell us how they want the services delivered and where they want them delivered.

The CHAIRMAN. In your Anchorage Service Unit system of care, is that a mobile system? In my notes you have a rural service unit in Alaska that is called an ASU or Anchorage Service Unit; is that correct?

Mr. EBY. Yes; there are 55 villages for which we are the primary care hub. Our eyes, our ears, our hands in those villages are the community health aides. There are two to four in each village. Then we have some regional hubs that are staffed by PA's and Nurse Practitioners. Then all that feeds into the physician-based systems.

We do send our physicians out two to four times a year to every single village. We send dentists out. We send optometrists out. But a great deal of what we do is over the phone and through the providers that are based in those locations.

The CHAIRMAN. I know unfortunately there is a high incidence of alcoholism among the native communities in Alaska. How do you integrate your health care with those injuries or problems that have alcohol-related origins.

Mr. EBY. Alcohol is a symptom of many deep-rooted causes, I am sure is not surprise to you.

The CHAIRMAN. Sure. Certainly.

Mr. EBY. Part of the reason we have built this things the way we have is that medical systems in the past have tended to deal with what the acute issue is, what that superficial layer is. It is sort of putting band-aids over a gaping wound.

By going to a more relationship-based system where the same nurses and the same doctors are dealing with the patient, the same family, and the same community over and over and over every time, you start to be able to get to the root causes. You start to

get to issues of depression, to violence, to family dysfunction, to substance abuse of all sorts, tobacco.

If you have a system where the providers are just interchangeable and you send one this time and someone else another time and someone else another time, you start at the beginning of the patient's story every time.

If you create a longitudinal relationship-based system, every visit builds on the previous one and you start to get to the underlying issues and quit treating the symptoms and start to treat the root causes.

The CHAIRMAN. Thank you. Also, in the former panel we discussed just a little bit about traditional healing and the involvement of traditional healing. I would assume that is very important with the Native Alaskan peoples, too.

Can you give me a couple of examples of how that works, how you integrate traditional beliefs and healing with modern science?

Mr. EBY. Right. In the last couple of years we have made a lot of advancement. In the past in Alaska they were kind of held at arm's length. Again, under tribal management it has changed completely, the philosophy around that.

We have a tribal doctor at Alaskan Aid Medical Center now. Part of the way we have worked out the interface is we have used a lot of terms that are familiar to medical people, so there is credentialling and privileging, but it is done in the Native traditional way.

We have a group of elders who sit in the room with the healer, feel their spirit and pass judgment on whether that person is going to represent them in the medical setting, not whether they are a traditional healer in the community, but whether they are accepted by the Native community as a tribal doctor in an approved, paid medical setting.

Then we work strongly with the medical staff and have pretty much fully integrated and a great deal of the credit goes to the traditional healing community themselves for being open to that interface.

The CHAIRMAN. Thank you. The last time I was up there, Senator Stevens and I and several others were in a little helicopter out of Barrow looking at the surrounding countryside. We came up over a rise and there was the biggest, most beautiful white bear I ever seen. He dove and took off.

We just went over the next rise and there was a man with a sled and a gun who was sneaking up on that bear. He was very unhappy with us. He waved at us. At least I think it was a wave.

Chairman Danforth, let me ask you a couple of things, too. Under the Joint-Venture Program, would the tribes being willing to assume partial cost for staffing for a facility which eventually would be assumed by the Indian Health Service?

Mr. DANFORTH. I think we would be open to negotiate those sort of costs associated with that, sir.

The CHAIRMAN. You mentioned the backlog of construction. We are well aware of that. As you probably know, the problem we have, of course, is that we are mandated by a budget resolution that we do not spend over a certain amount of money.

That is how we managed to get this terrible deficit under control after two decades of spending more than we took in. So that means there is a terrific tug of war around here, as you probably know.

When we try to put more money into one part of the budget, we are mandated to have what are called "offsets," to find it somewhere else in the budget, to take it out of some other thing. It is very difficult to do.

Through the Interior Appropriations Committee, I sit on that committee with Chairman Gorton, I think, as I understand it, we are going to put about $15 million more into the Joint-Venture section. I think he is supportive of that. It probably still is not enough. We are trying to do the right thing. Fortunately, we have several other members of this committee that are also on that Appropriations Committee. So, we will be trying to do our best. I just wanted you to know that.

Well, I have no further questions, but I certainly appreciate your being here.

For those of you who want to have some input to this particular issue, we are going to keep the record open for 2 weeks. So, if there is anything you would like to add, Dr. Eby and Chairman Danforth, I would appreciate that.

If anybody in the audience would like to extend other comments, we will keep the record open for 2 weeks.

We will also probably followup with some questions in writing, too, that may be of a technical nature.

With that, I thank you. This committee is adjourned.

[Whereupon, at 11:02 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

In exchange for the session of millions of acres of tribal land, the Indian nations purchased the first pre-paid health care plan and the United States assumed the responsibility for the provision of comprehensive health care services to all American Indian and Alaska Native citizens.

Since its enactment in 1976, the Indian Health Care Improvement Act has served as the cornerstone for the provision of health care services in Indian country, initially by the Indian Health Service, and currently, as the foundation for a three-tiered health care delivery system that includes reservation-based tribally operated health care programs and urban Indian health care programs.

However, while much progress has been realized in achieving the act's objective of raising the health care status of native people to the "highest possible level", the unmet health needs of the American Indian people today remain alarmingly severe, and in some instances, the health status of Indians remains far below that of the general population. For example, Indian people suffer a mortality rate from diabetes that is 249 percent higher than that for the United States all races; a mortality rate from pneumonia and influenza that is 71 percent greater; a tuberculosis death rate that is 533 percent greater and a mortality rate from alcoholism that is 627 percent higher than the rate for all races in the United States.

Today we will consider titles I, II, and III of the Indian Health Care Improvement Act. The changes and modifications that have been proposed to these titles hold the potential for improving and enhancing the ability of tribal health care programs, urban Indian health programs, and the Indian Health Service to provide comprehensive primary health care and public health services to all eligible American Indian and Alaska Native people.

I join the chairman in welcoming all of the witnesses to this hearing. We look forward to receiving your testimony.

Testimony on Proposed Legislation to Reauthorize the Indian Health Care Improvement Act P.L. 94-437

Senate Committee on Indian Affairs
May 10, 2000

Presented by
Taylor McKenzie, M.D.
Vice President of the Navajo Nation

Thank you for the opportunity to present the Navajo Nation's position on the proposed legislation reauthorizing the Indian Health Care Act of 1976 also known as Public Law 94-437. As a former surgeon on the Navajo Nation, it gives me great pleasure to outline recommendations for the reauthorization of this important piece of legislation.

In early 1999, Indian Health Service (I H S) sponsored a series of regional meetings between health care providers from tribal and urban Indian healthcare programs to discuss specific healthcare concerns in Native communities and make recommendations regarding the reauthorization of the Indian Health Care Improvement Act, due to expire in September of this year.

In June representatives from tribes, tribal organizations and urban Indian organizations (I/T/Us) formed the National 437 Steering Committee. Charged with addressing the recommendations and conflicts from the regional meetings, the committee drafted the proposed reauthorization legislation being considered today.

The following areas of the proposed legislation are supported by the Navajo Nation:

Scholarships - Title I - Sections 2 and 3

The Navajo Nation concurs with assertions made in this Section that the United States government has a responsibility to ensure that the health of Native Americans is up the standards outlined for the rest of the population in its "Healthy People 2000" declaration. The Navajo Nation supports this section in recognizing the need for more Native American

healthcare providers and the stipulations of this section that provide for equal funding for tribally operated healthcare facilities as is provided for I H S facilities.

Title I of 94-437 gives a higher degree of autonomy to ITUs in that it provides for funding for I H S scholarships to Indians as described in Section 4 of this legislation to be funded through area offices. That individual service areas will award scholarships and service contracts will be fulfilled in the areas providing the scholarship unless otherwise agreed to, gives a higher level of control to ITUs in being able to plan for their healthcare needs and select their providers. It also means that more scholarships will be provided for federally recognized Native Americans, thus ensuring a higher degree of commitment from health care providers under these scholarships. Title I also provides for scholarships for a wider range of healthcare professionals. The Navajo Nation in recognition of the wide variety of health care providers ranging from physicians and nurses to community health representatives and pharmacists to drug and alcohol counselors and health educators, supports this increase in healthcare opportunities for Indian people. Navajo Nation also recognizes the need for a higher degree of cultural relevance in services provided to Indians. Section 117 of Title 3 requires tribal consultation in the design and delivery of training in the culture and history of the tribe scholarship recipients are to serve as an important step in ensuring that Native Americans receive care from Indians who are aware of cultural ramifications that might affect the quality of care given and the patient's receptivity to both the provider and the health solutions he or she offers.

Environmental Health/ Title II - Section 215

Section 215 calls for study and monitoring programs to determine trends that exist in health hazards posed to Indian miners and Indians on or near reservations and in Indian communities as a result of environmental hazards that may result in chronic and or life threatening diseases. The Navajo Nation supports consultation with tribes and tribal organizations regarding these

trends and stresses the importance of consultation as it allows tribes to take part in their destinies and is a true step toward self determination.

The Navajo Nation also supports the inclusion of studies with summaries of findings, reports and plans of action. A task force comprised of leadership from pertinent agencies will administer the plan. The Navajo Nation approves of the defined composition of this panel due to its ability to scrutinize data accurately and make educated determinations regarding Navajos affected by environmental hazards while in employment situations.

According to this facet of the reauthorization of P.L. 94-437, Indians who suffer work related illnesses or conditions as a result of uranium mining or milling will be eligible to receive diagnosis and treatment from an I H S facility. Medical care will be paid for by the owner of the facility responsible for the environmental hazard. The I H S can request reimbursement from such entity. This section does not nullify the right to recover damages other than medical expenses. The Navajo Nation supports this section because it provides for the compilation of accurate data regarding environmental health issues among Navajos along with components for education, prevention and treatment while requiring the entities charged with causing the health problems to take responsibility and rectify the damages.

Contract Health Service - Title II - Section 216

Another area of concern to the Navajo Nation is the retention of Arizona as a contract health service delivery area. At present time, the State of Arizona is designated as a contract health service delivery area by the I H S. Arizona must continue as a contract health service area until the end of Fiscal Year 2012, providing services to members of federally recognized tribes within the state. Services to Indians on reservations in Arizona will not be curtailed under this section. The Navajo Nation supports Section 216 because of the large numbers of Navajos living in urban areas such as Flagstaff, Phoenix, Tucson and other non-reservation areas. I H S

facilities are often difficult for Navajos living in these areas to access. This is especially true in critical care situations.

Facilities - Title III

This Title concerns monies spent on construction and or renovation of I H S facilities. Title III stipulates that the Secretary of HHS acting through I H S shall consult with the tribe that will be significantly affected by the facilities expenditure for the purpose of determining and honoring tribal preferences concerning that facility. The Secretary and I H S are to ensure that the proposed facility meets the construction standards of a nationally recognized accrediting body not later than a year after construction/renovation.

The Navajo Nation supports this Title and acknowledges the importance of local input regarding federally run facilities in related areas. Without tribal input regarding construction and renovation of facilities, there exists a concern that monies earmarked for such construction costs will not be spent in ways consistent with tribal needs or preferences and that additional expenses will be incurred when efforts to correct these issues are undertaken. The hiring of Navajos in the building trades is also an important issue in the Navajo Nation. Tribes must be consulted prior to the undertaking of any construction or renovation projects situated on tribal land and or servicing a majority Native population. This is consistent with the principles of self determination and is often a term of the funding provided for the facility.

Priority System - Section 301(c)

I H S has never been fully funded and therefore, must prioritize projects to ensure eventual completions. This section of the Indian Health Care Reauthorization Act establishes a health care priority system along with tribes and tribal organizations. Under this title, highest priority will be based on the needs of tribes. A list of the planning, design, construction and renovation needs will be established. The top ten priority inpatient care facilities, outpatient facilities and

specialized care facilities will be listed along with justifications for the order of the priorities, the projected costs and the methodologies used will also be listed.

The above-described methodology will include consultations with tribal governments and tribal organizations and a review of total unmet needs. This Section is important to the Navajo Nation because it requires more consultation with tribal governments prior to establishing priorities that affect Indian communities, an important component of self determination.

While outlining a priority system designed to address critical healthcare needs in Indian Country, there exists nothing in this section that stipulates a time period in which Indian healthcare needs will be met with the goal of ensuring that all communities in need will have facilities built and in operation by a specified date, the Navajo Nation encourages Congress to appropriate additional funding to build and or renovate health facilities serving a majority Indian constituency and to establish dates of completion so communities can project patient numbers, staffing needs, etc.

Comprehensive Behavioral Health Program

The Navajo Nation is in full support of the new provisions under Title VI to develop and operate a comprehensive behavioral health prevention and treatment program which places emphasis on collaboration among alcohol and substance abuse, social services and mental health programs. Revisions clarify that the Indian tribes and tribal organizations have responsibilities to develop plans which provide for a wider range of behavioral health services for families and individuals. These services can include but are not limited to community based prevention, early intervention, outpatient and behavioral health aftercare, acute hospitalization, transitional living, traditional health care practices, parenting education, youth programs, etc.

Data suggests a link between substance abuse, domestic violence, accidental death and a variety of other health issues present in reservation communities. The unification of programs under one banner is not only consistent with Navajo cultural practices, but will streamline the

assessment process and enable mental health providers to better serve their clients in a more cost effective way.

Non-Service Funds for Renovation - Section 305

Section 305 requires that the Secretary of Health maintain a separate priority list for increased funding for staff, equipment or other operating expenses supported by the tribal government. The Navajo Nation recognizes that an important component of the building of I H S facilities is the inclusion of funding for staff quarters, infrastructure and administrative costs for I H S facilities and or tribally run health care facilities. Medical facilities in Indian Country are often located in rural areas with few if any rental properties, either residential or commercial available. This is a strong concern in the recruitment and retention of qualified medical providers and support staff.

Joint Ventures - Section 312

The Navajo Nation supports Section 312 of the proposed legislation, which provides for I.H.S./Tribal Joint Venture Programs. Under this section, tribes can enter into joint ventures where tribes lease the facility for ten years to I.H.S., at no cost, and I.H.S. provides monies for staffing and equipment. Given the difficulty in finding funding for health care facilities and the enormous backlog on the I H S list of priorities, the Navajo Nation is in support of Section 312 as an innovative way to meet the healthcare facility needs of the Navajo Nation. However, there are instances where tribal governments are not in the financial position to provide matching funds to I H S projects. The Navajo Nation supports additional congressional funding to match these funds in instances where the tribal government is not in the position to do so.

Third Party Payors - Title IV

Many Native Americans are eligible for programs that provide healthcare to Indians under other federal and or state programs. In many I H S facilities, the operating budget consists of 50 to 60 percent funding from third party payors. Efforts to enhance collections enable these facilities to better plan for and provide services to clients.

Title IV of 94-437 enables I H S, tribes, tribal organizations and urban Indian Organizations to bill Medicare, Medicaid and Children's Health Insurance Program for services provided to Indians under the Social Security Act. These monies are not considered in determining appropriations for Indian health care and shall be paid for eligible services regardless of location. Outpatient facilities are eligible if they collaborate with a hospital or other inpatient facility.

Yet at the same time, it is important to recall that health care for tribal members is ultimately a trust responsibility. In keeping with this, the Nation objects to the language added to the proposed section 408(f), which provides an exception and would under certain circumstances allow IHS to bill Tribes for services provided to members. While it is understandable that IHS may need money, it is inconsistent with the federal trust responsibility to bill the beneficiary for services.

In subsection (h) "tribal" should be added to "Federal or State law" as neither state law, nor state court may have jurisdiction over a claim an individual may bring against an insurer for services provided at an on-reservation facility.

Section 410(b) allows recovery from managed care plans for services, for the same reasoning noted above opposing the additional language in 408(f), the Nation proposes that tribally self-funded managed care plans be excluded from the sources of recovery.

Tuba City Demonstration Project - Section 412

Specific to the Navajo Reservation is Section 412, which addresses the Tuba City Demonstration Project. Under this section, the I.H.S. will act as a Medicaid managed care organization in Arizona for people who use the Tuba City service unit. I.H.S will provide Medicaid services in return for a uniform per capita payment from the State of Arizona.

Of course the provisions in the proposed legislation relating to the development of the Navajo Nation "Tri-State Medicaid Agency" are particularly important to the Navajo Nation. This provision would provide the authorization for the Health Care Financing Administration to work with the Nation to provide a uniform rate for medicaid reimbursement eligible services. Currently on the Navajo Nation there are three sets of rules with respect to medicaid reimbursable services - one for each of the states. Having one set of procedures should improve the processing of reimbursements. Additionally, since the Navajo Nation will operate this Medicaid system, we anticipate that the services can be more culturally relevant to the Navajo population.

While the language as proposed sets up this opportunity, upon further reflection some minonr revisions to the proposed language will enhance the ability of the Navajo Nation, and perhaps eventually other Tribe to be more self-determining in this critical area: Section 401(d) as drafted, creates the Qualified Indian Health Program (a new Sec. 1880A), in subsection (c)(5) of the proposed sec. 1880A the full cost recovery rate is to be determined by "the Health Care Financing Administration or by a State Medicaid agency..." To allow for the development of the Navajo Nation Medicare Agency, this language should be changed to read: "the Health Care Financing Administration or by a Medicaid agency recognized by the Health Care Financing Administration..."

Similarly under section (d)(4) there is a reference to a "State Medicaid plan," this should be changed to "operative Medicaid plan" or other such similar language to allow for the development of tribal Medicaid plans.

Section 402(c) amends sec. 1911, which makes substantial reference to "state plans" unless a "catch all" provision is included in the Navajo Nation Medicaid demonstration project section, this should also reference "tribal plans."

Section 404(c) adds language to allow IHS to enter into agreements with a state to facilitate eligibility determinations for M&M recoveries. Given that some states have eligibility determinations made at county or local levels, it would seem appropriate to insert "county and local governments" after "State." On a similar level, this whole section seems unfortunately complex. Under subsection (a) IHS can enter into funding agreements with tribes and tribal organizations for eligibility determinations and enrollment in a state plan. In practice on the Arizona portion of the Navajo Nation, what happens is that IHS gives the Nation these funds, and the Nation then contracts with the county governments for the counties to hire eligibility workers, since otherwise, the Office of General Counsel for IHS has determined that an Intergovernmental Personnel Agreement is required. While this arrangement works, it seems unnecessarily cumbersome; subsection (c) may help address this if "including funding agreements" is inserted after "agreements" in the added language. Otherwise the contracting authority in subsection (a) could be expanded.

Section 405(b)(1) provides that a '638 contractor reimbursed for M&M or CHIP services. Further, "Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used to provide additional health services or improvements in its health care facilities." This statement may conflict with the sections in '638 regarding the use of program income, which can be used to provide additional services under the contract scope of work. While in most cases there will be no conflict - the "additional health services" would be consistent with any given scope of work, it is possible that there might be an inconsistency. Add "consistent with the Indian tribe or tribal organization's contract pursuant to the Indian Self-Determination and Education Assistance Act" at the end of the sentence.

Funding of Unmet Needs and Level of Need Funding

Native American communities have never had their healthcare needs fully met. The Indian Health Service Level of Need Funded resource allocation methodology has outlined a more effective way to address Indian healthcare needs on a national basis. This methodology should be used to address unmet healthcare needs in the Native American/Alaska Native communities. According to the LNF study, I H S is serving only 1.24 million of a total 2.4 million population of Native Americans. The cost is about $2 billion annually. The Navajo Nation is in support of the recommended $7.4 billion yearly budget for adequately serving the Native American/Alaska Native population. This $2,980 per person per year is still beneath the federal and or state healthcare spending levels for non-Indians.

National Bipartisan Commission on Indian Health Care Entitlement

The Navajo Nation is in support of the new provision under Title VIII to establish a 25-member National Bipartisan Commission on Indian Health Care Entitlement to study the provision of health care to Native Americans and Alaska Natives as an entitlement. The Navajo Nation recognizes the unique relationship between Native peoples and the United States government and the federal government's admitted responsibility to Native health care. The Navajo Nation supports this Title as a mechanism to improve delivery of services to Native Americans.

Expansion of Diabetes Prevention and Treatment Program

Diabetes continues to ravage Indian communities. Type 2 or Adult Onset Diabetes is of particular concern as it is affecting Indians in greater numbers at lower age groups. Estimates from I H S and the CDC suggest that an average of 45% of the total Native American community is affected by diabetes. Diabetes is listed as the fifth cause of death among Navajos. Navajos die from diabetes at a rate two thirds higher than the national average. A section under Title II has been revised to eliminate a specific list of model diabetes projects and

move toward establishing more comprehensive diabetes prevention and treatment programs. The Navajo Nation is in full support of expanding the diabetes program with funding.

Inpatient Rehabilitative Therapy

While covering outpatient rehabilitative therapy, I H S does not pay for inpatient rehabilitation. This is often problematic since according to medical professionals interviewed at rehabilitative facilities that are frequented by Native patients, the inability of Indians to enter into inpatient rehabilitative therapeutic situations places them at higher risk for re-injury and slows the pace at which they ultimately recover. Outpatient rehabilitative therapy for patients who have experienced strokes, cranial injury or spinal cord injuries often includes long drives to and from facilities and inconsistent care often resulting in impeded recoveries and re-injuries. Ultimately, the expenses incurred in these situations are higher than the inpatient therapy. The Navajo Nation strongly urges the inclusion of inpatient rehabilitative therapy and other therapies recommended by attending physicians or other health care providers under I H S benefits.

Cultural Issues

Staff at most health care facilities that treat large numbers of Indians rarely speak the Native language or have a clear understanding of the cultures they are serving. The presence of a tribal member familiar with the language and customs of his/her constituency is vital to the quality of Indian healthcare, especially in situations where large numbers of elderly frequent the facility.

The Navajo Nation supports partnerships with I H S facilities or private health care organizations in maintaining staff who speak the dominant Native language and are trained to assist in the delivery of services such as therapies, patient care, nutritional consultation, tests along with cultural and religious consultation to other staff members, networking with Indian communities.

Conclusion

In closing, I thank you for your consideration and urge your continued support for the reauthorization of P.L. 94-437, the Indian Health Care Improvement Act. Of course if the Committee requires further information or assistance with respect to any of the suggestions put forth by the Navajo Nation, we stand ready to work with the Committee.

THE NAVAJO NATION

Kelsey A. Begaye, *President* **Taylor McKenzie, M.D.,** *Vice-President*

00 JUN 26 AM 10: 28

June 19, 2000

Honorable Ben Nighthorse Campbell
Chairman
UNITED STATES SENATE
Committee on Indian Affairs
Washington, DC 20510-6450

Dear Senator Campbell

Thank you for your letter of May 24, 2000 posing several questions in regard to the Reauthorization of the Indian Health Care Improvement Act in follow-up to the May 10th hearing.

I trust the information provided in response will be of considerable help. Thank you for the opportunity to testify on behalf of the "Reauthorization of the Indian Health Care Improvement Act".

Sincerely,
THE NAVAJO NATION

Taylor McKenzie, MD

Taylor McKenzie, MD, Vice President

P.O. Box 9000 • Window Rock, AZ 86515 • (520) 871-6352 • Fax: (520) 871-4025

ATTACHMENT

Response to the four questions raised in
Senator Ben Nighthorse Campbell's
letter dated May 24, 2000

1. **You mentioned in your testimony that the changes to the scholarship provisions will attract more federally recognized American Indian and more "committed" individuals. How?**

The provisions would allow tribes control over their scholarship resources. This responsibility and ownership would allow tribes to administer their own scholarship programs for their tribal members. Tribes know their tribal members and understand the needs and priorities for their tribes in relation to health care needs/issues; therefore they would be in better position to establish scholarship programs that would truly reflect and meet their needs. They can institute screening mechanisms for the selection for qualified tribal members based upon their priorities and eligibility requirements. Tribal members selected directly from their own communities are more likely to return to their people to practice. Such tribal members who are scholarship recipients grew up in the local tribal communities, they know the expectations of their communities, they are aware of the issues/concerns and r.eeds of their communities, they are in a better position to initiate positive changes in their communities, they are in a better position to initiate positive changes in their communities, they have the tribal-family support, etc. Tribes can focus on their "selectees" and put in the effort to provide moral and financial support to see these scholarship recipients through. Through having a voice in their scholarship resources, tribes are in fact committing to their young people to get them through school. Tribes can groom their young people to meet eligibility requirements set by the tribes. Tribes can set expectation for higher education and the rewards that come with it if you succeed.

2. **Please explain to me how the designation of the State of Arizona contract health service area benefits tribes. What would happen if Arizona were not a contract health service area?**

See attached information on Contract Service Delivery Area (CHSDA).

3. **How many Navajo live off the reservation in urban areas? Which urban areas have high numbers of Navajos living in them?**

According to the 1995 Navajo Nation Profile, which is based on the 1990 census, the estimated number of Navajo population in the United States (in 1995) was 259,556. The estimated number of Navajo persons residing off-reservation was 100,075. Excerpts of the 1990 census report is attached.

4. **Your plan to designate dates for completion of tribal facilities contraction for specific projects was interesting. Can you explain how that would work in more detail and how this would benefit tribes?**

Currently, there is nothing in Section 301 (c) that stipulates a time period in which Indian healthcare needs will be met with the goal or ensuring that all communities in need will have facilities built and in operation by a specified date. The designation of dates for completion of tribal facilities construction will allow communities to project patient numbers, staffing needs, etc.

QUESTION: **Explain How The Designation of the State of Arizona Contract Health Service Area Benefits Tribes. What would Happen If Arizona Wer Not A Contract Health Service Area?**

PROPOSED - Generally, the contiguous counties in the State of Arizona are defined by the IHS as a Contract Health Service Delivery Area (CHSDA), namely Navajo Area, Phoenix Area, and Tucson Area. To be eligible for CHS, any beneficiary residing with the CHSDA, but not on the reservation, must be a member of the tribe or tribes for which the reservation was established or "maintain close economic and social ties" with the tribe or tribes. Under the current rule, if a member of a different tribe moves to a CHSDA but does not reside on the reservation, he/she is eligible for direct care but not for CHS care unless he/she has close economic and social ties to the tribe for which his/her reservation was established.

It is not uncommon for tribal members to live near a reservation but in a county that is not contiguous with the reservation (i.e. outside the CHSDA). As long as an Indian beneficiary is a member of a Federally-recognized tribe and resides in a CHSDA, the Indian beneficiary is eligible for CHS care and direct care. If an Indian beneficiary moves near or on another Indian reservation, within the State of Arizona, he/she will not lose eligibility for CHS. The close and social ties test will be eliminated.

In addition, Tribes have mechanism for requesting a redesignation of a CHSDA---any Indian tribal government may request a change in the boundaries of the CHSDA. Further, the IHS many designate States such as counties or towns, or other identifiable geographic areas as CHSDAs where reservations are inappropriate as the basis for defining a CHSDA. Consideration to include: number of persons residing off-reservation who would be eligible for IHS services; number of persons residing off-reservation who have traditionally received IHS health care services but whose eligibility would be affected; the geographic proximity of the off-reservation area to a reservation; and whether IHS beneficiaries residing off-reservation can be expected to need and to use health services provided by the IHS. Given this information, the IHS Director, or his designee, makes the final decision on the tribe's request.

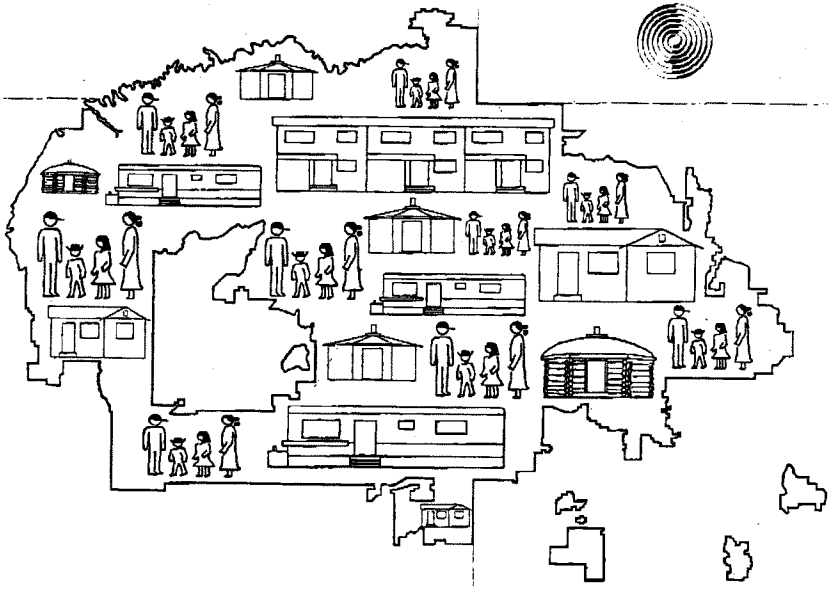
CURRENT - The CFR, Title 42, Section 36.32 (1986) stated that CHS will be made available to otherwise eligible federally recognized Indians who do not reside on a reservation, if they reside within a CHSDA, and (1) they are members of the tribe(s) located on the nearby reservation or of the tribe(s) for which the reservation was established or (2) if they maintain close social and economic ties with than/those tribe(s). A CHSDA is defined as any county that contains all or any part of a reservation or that shares a common boundary with a reservation unless specified by Congress. The regulation also states that, except for transients (migrant workers, travelers, etc.), foster children, and full-time students in institution or higher learning or in Indian boarding schools, federally recognized Indians who leave the CHSDA in which they have CHS eligibility will remain eligible for CHS for a period not to exceed 180 days.

25 U.S.C. 1678 (b) makes it clear that the IHS may not implement Section 1678 (a) by taking funds from services provided to Indian living on reservations. The Senate Report (Senate Report 96-758, at 26 [1980]) accompanying that bill stated that the Committee language assures that reservation health care services will not be diminished because of the designation of Arizona as a single CHS delivery area. The Conference Report (H.R.

Conf. REP 96-1483, at 14, 15 [1980]) accompanying the legislation further stated that no funds were to be made available to implement this section unless specifically appropriated. According to H.R. Rep. 102-643 (I) at 447, 448 (1992), Congress estimated that it would cost $65 million in FY 97 to fully fund the provision to cover all eligible Indians. Consequently, until Congress specifically appropriates funds for section 1678 (a), the IHS is unable to implement the section that states: "that the State of Arizona shall be designated as a CHSDA for the purposes of providing CHS".

1990 CENSUS

CENSUS '90



POPULATION and HOUSING CHARACTERISTICS of the NAVAJO NATION

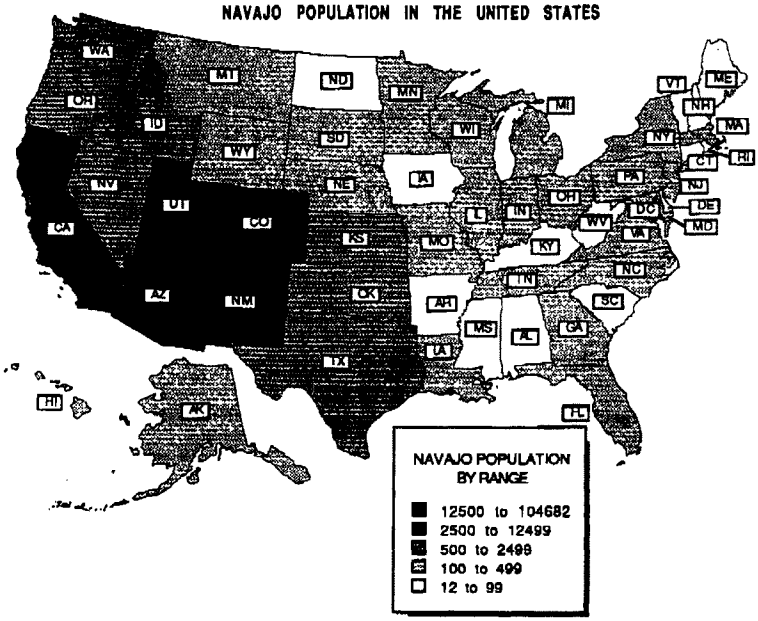
17

Table US05: TOTAL AMERICAN INDIAN AND NAVAJO POPULATIONS BY STATE AND REGION: 1990

	TTL AM IND POP	NAVAJO POP	PERCENT NAVAJO
UNITED STATES	1,878,285	219,198	11.67
REGIONS/DIVISIONS			
Northeast	121,551	946	0.78
New England	31,986	289	0.90
Middle atlantic	89,565	657	0.73
Midwest	333,998	2,448	0.73
East North Central	147,399	1,178	0.80
West North Central	186,599	1,270	0.68
South	557,214	4,420	0.79
South Atlantic	169,554	1,489	0.88
East South Central	40,220	306	0.76
West South Central	347,440	2,625	0.76
West	865,522	211,384	24.42
Mountain	478,391	201,174	42.05
Pacific	387,131	10,210	2.64
STATES			
New England			
Maine	5,945	30	0.50
New Hampshire	2,075	22	1.06
Vermont	1,650	12	0.73
Massachusetts	11,857	136	1.15
Rhode Island	3,987	25	0.63
Connecticut	6,472	64	0.99
Middle Atlantic			
New York	60,855	273	0.45
New Jersey	14,500	172	1.19
Pennsylavania	14,210	212	1.49
East North Central			
Ohio	19,859	275	1.38
Indiana	12,453	139	1.12
Illinois	20,970	394	1.88
Michigan	55,131	254	0.46
Wisconsin	38,986	116	0.30
West North Central			
Minnesota	49,392	145	0.29
Iowa	7,217	55	0.76
Missouri	19,508	228	1.17
North Dakota	25,870	53	0.20
South Dakota	50,501	151	0.30
Nebraska	12,344	112	0.91
Kansas	21,767	526	2.42
STATES (Continued)			
South Atlantic			
Delaware	1,982	18	0.91
Maryland	12,601	221	1.75
District of Columbus	1,432	18	1.26
Virginia	14,893	266	1.79
West Virginia	2,385	36	1.51
North Carolina	79,825	276	0.35
South Carolina	8,049	82	1.02
Georgia	12,926	188	1.45
Florida	35,461	384	1.08
East South Central			
Kentucky	5,614	85	1.51
Tennessee	9,859	100	1.01
Alabama	16,312	72	0.44
Mississippi	8,435	49	0.58
West South Central			
Arkansas	12,641	88	0.70
Louisiana	18,361	101	0.55
Oklahoma	252,089	924	0.37
Texas	64,349	1,512	2.35
Mountain			
Montana	47,524	335	0.70
Idaho	13,594	715	5.26
Wyoming	9,426	244	2.59
Colorado	27,271	3,604	13.22
New Mexico	134,097	77,927	58.11
Arizona	203,009	104,682	51.57
Utah	24,093	12,861	53.38
Nevada	19,377	806	4.16
Pacific			
Washington	77,627	774	1.00
Oregon	37,443	617	1.65
California	236,078	8,538	3.62
Alaska	31,245	138	0.44
Hawaii	4,738	143	3.02

SOURCE: 1990 Census; CPH-L-99; Extracted by DCD

NAVAJO POPULATION IN THE UNITED STATES

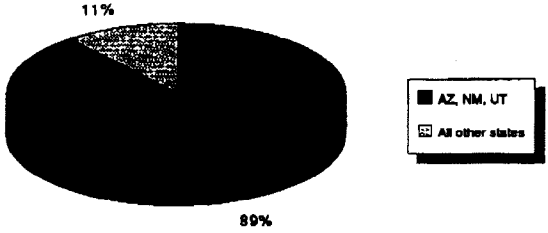


NAVAJO POPULATION BY RANGE

- 12500 to 104682
- 2500 to 12499
- 500 to 2499
- 100 to 499
- 12 to 99

Arizona, New Mexico, and Utah have a combined Navajo population of 195,470 - representing 89% of all Navajos in the United States. The top ten states, in order of rank, are: Arizona, New Mexico, Utah, California, Colorado, Texas, Oklahoma, Neveda, Washington, and Idaho. These make up a total Navajo population of 212,343 or 96.9% of all USA Navajos.

Navajo Population by Three-State Area and Remainder of U.S.



SOURCE: 1990 Census; Graphics by DCD

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

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SENATE INDIAN AFFAIRS COMMITTEE HEARING ON LEGISLATION TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

Wednesday, May 10, 2000

9:30 a.m.
485 Russell Senate Office Bldg.

Julia A. Davis,
Nez Perce Tribe Executive Council
Northwest Portland Area Indian Health Board
National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act

Testimony May 10, 2000
Senate Indian Affairs Committee

Co-chairs Campbell and Inouye, thank you for inviting me to testify today on the Indian Health Care Improvement Act. I am Julia Davis, recently reelected member of the Nez Perce Tribe's Executive Council. I am also Vice Chair of the National Indian Health Board and Chair of the Northwest Portland Area Indian Health Board. Thank you for this opportunity to testify on behalf of the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. The NSC Committee appointed a Reauthorization Leadership Group and I am one of its six members. Today I would like to review Title III, the facilities section of the draft bill on the Reauthorization of the Indian Health Care Improvement Act (PL 94-437).

As others will mention today the draft bill is the Senate version of the consensus bill developed by tribes last May through October in what was a good example or perhaps model is a better word of a good consultation process. This bill was developed by tribes and urban Indian groups and reviewed and commented on by American Indians and Alaska Natives nationwide.

I was the co-chair of the Facilities workgroup within the National Steering Committee. I was pleased with the cooperative spirit that attended the developed of Title III. I want to acknowledge the hard work of those who contributed to this section of the bill including my co-chair Robert Nakai of the Albuquerque Area. Tribes donated valuable staff time and the Indian Health Service provided additional technical support. I think it is a strong section that if passed as proposed would vastly improve the sorry condition of the facilities infrastructure of Indian health programs.

Before I review the bill I would like to say just a few words about federal funding for health facilities. Medicare and Medicaid provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare or Medicaid program. Yet American seniors receive care in the most modern clinics and hospitals in the world. Indeed it is remarkable, but true, that poor Americans who are eligible for Medicaid in Washington, Oregon, and Idaho now receive their care in the same facilities as other non-poor Americans, that's right, in the very same clinics and hospitals that are the envy of the world.

What about Indian people? Their clinics, with notable exceptions are old, on average more than 30 years old. My clinic in Lapwai, Idaho is over 40 years old. The Clinic director has her office in a windowless basement room. Many of our clinics are mobile homes really. Often, when one of our tribal members becomes eligible for Medicaid they choose to drive 20 miles to Lewiston to see a doctor in a modern facility, not in our Nee Mee Poo clinic.

The clinics are not just old. They are inadequate. They are too small, the equipment is often outdated, and the staff is forced to make do as best they can. That is, the staff that is willing to stay under these less than desirable conditions. My tribe just lost a native doctor to an urban clinic. Who can blame someone for not wanting to work up to their potential in a modern facility with start of the art equipment?

What explains the poor condition of so many Indian clinics?

Unfortunately, it is the budget process itself that annually underfunds the Indian Health Service budget that is the cause of the poor condition of our facilities. There is no doubt that again this year little progress will be made to address our backlog of facilities need. As a discretionary program the Congress will ask tribes the annual question: Do you want this year's proposed $229 million increase to go to health services programs or facilities? This choice is unfair. No one asks Medicare recipients if they want facilities or programs---they get both. The health plans that deliver care to Medicaid and Medicare patients take out a portion of each dollar paid by these programs to provide adequate facilities. It is bad health care and bad business to have poor facilities. The idea of slicing off a portion of our inadequate health services dollars for facilities is not realistic. There is nothing to slice. Because the Indian Health Service is a discretionary program our funding is limited and proposals for facilities construction are the low hanging fruit that is chopped off every year. In fact, I think it is wrong that we don't ask for more than we do each year.

What is new in Title III of the draft bill?

Our general goal was to grant authority to tribes and the Indian Health Service to meet our need. I have little hope that these authorities will produce the funding needed to meet that need, however. We reaffirmed our support for existing alternative financing mechanisms like joint venture and

proposed new ones like a revolving loan fund to finance facilities construction. In the Northwest, we believe innovative financing of facilities will reduce that gap between our current facilities and our need.

The new title requires the Secretary to develop a new priority system for construction through negotiated rulemaking with tribes, tribal organizations and urban Indian organizations. The consensus bill does include a provision that recognizes that many tribes have waited a long time under the existing system and states that the existing priority list will be used for projects in phase 1 and 2 of construction. An annual report would be required of the need for new facilities; inpatient, outpatient and specialized care facilities. Northwest tribes have expressed the desire that this report take a close look at the need for new inpatient facilities as opposed to alternatives such as clinic construction and expanded contract health dollars to meet the need.

The Sanitation section also tries to promote aggressive cooperation between agencies to maximize revenues to meet the need. It also encourages closer cooperation between the Indian Health Service and tribes to understand and meet sanitation needs. It gives the Indian Health Service the authority to enter into inter-agency agreements with State and Federal agencies to maximize funding opportunities.

For Maintenance and Improvement the new act requires a report to the Congress and President on the backlog of maintenance as well as the expansion and renovation needs of health program facilities. The new section also allows M & I funds to be used to build new facilities if the cost is less than 80 % of what would be spent on repairs.

The staff quarters section allows tribes to set the rental rates for the quarters and authorizes tribes to directly collect rents from federal employees.

I think the proposed Title III section has widespread support. In the Northwest we have presented the title to our Board and at two special meetings, one on December 15, 1999 and at another meeting of direct service tribes on April 14, 2000. I can report to you that our tribes have not expressed any serious reservations about Title III, however I would understand if some tribes would like to have more time to fully understand this section of the bill. Thank you and I would be happy to answer any of your questions.

Julia Davis, Chair Northwest Portland Area Indian Health Board

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
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Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
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Yakama Nation

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July 18, 2000

Honorable Ben Nighthorse Campbell
Senate Committee on Indian Affairs
838 Hart Building
Washington, DC 20510

Dear Chairman Campbell,

Thank you for your letter of May 24, 2000 and your questions regarding the October 6, 1999 draft bill for the reauthorization of the Indian Health Care Improvement Act. I would like to respond to your questions from the perspective of both the National Steering Committee and the member tribes of the Northwest Portland Area Indian Health Board.

Your first question concerns the definition of Indian contained in the draft bill.

Definition of Indian

I do not believe there was a conscious choice to reduce the number of Indian people who are eligible for services from the Indian Health Service. You are correct in noting that the definition used in the National Steering Committee draft would be more restrictive than the current practice of requiring only Indian descent for the use of direct service provided by Indian health programs. The proposed bills (HR 3397, S. 2526, and the N.S.C. draft) all cite the P. L. 93-638 definition of Indian as meaning someone who is a member of a federally recognized tribe. I frankly do not recall any discussion of adopting this definition as a way to reduce the number of eligibles. I do know there was a desire to emphasize that the trust responsibility for health care is between tribes and the federal government and the P.L. 93-638 definition emphasizes the government-to-government relationship. Your observation, however, is also true. It does allow an interpretation that would restrict eligibility.

The second N.S. C. draft of the act contained the following definition comparable to current law and this was changed in the forth and the fifth (final) version of the proposed National Steering Committee bill.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of section 102 and 103, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the

Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

With the exception of authorizing services to 'state-recognized' tribes the National Steering Committee had no real problem with the current law definition. I know the National Steering Committee would not support the definition to include state-recognized tribal membership making someone eligible for services of the Indian Health Service.

There was certainly no intention to restrict the eligibility of urban Indians. In fact, the National Steering Committee agreed to add a separate definition to reflect their historical circumstances.

I think the draft definition does not cover the desired categories of persons that are covered under current law and the National Steering Committee will offer a recommended amendment to be sure we do not make the definition too restrictive.

There are two other provisions in the act that deal with the issue of eligibility and the definition of Indian. One is section 811 that would require negotiated rulemaking to set eligibility criteria. Another is section 816 that establishes a national Bi-Partisan Commission on Indian Health Care Entitlement that would have one of its charges be a review of the definition of Indian and eligibility.

In response to question 2 regarding dialysis machines, I do remember discussions about the need, but I also remember questions being raised about whether or not authorizing language was needed for such a narrowly defined service. The feeling was that because of barriers to access due to remote location and high cost the new act should highlight the need for dialysis with a specific authorization. Again, the National Steering Committee may want to revisit this issue and I will recommend that they do so.

In response to question three, there are several new and expanded provisions that will create new opportunities to meet our facilities needs.

Title III Construction Opportunities

Many provisions of Title III offer alternative means for tribes and tribal organizations served by IHS-funded health programs to finance construction and renovation of health care facilities. They may be used independently of each other or in combination to build facilities outside the present IHS Construction Priority System and address the critical health care facility needs in Indian country. The primary new construction financing provisions are:

Section 305 is modified to authorize the IHS to accept expansions of existing facilities financed by sources other than IHS.

Section 306 strengthens the existing, but not funded, program for grants to construct and renovate small ambulatory care facilities in the hope that this section more likely will be funded.

Section 307 authorizes contracts, grants and loans for testing alternative means of constructing or renovating Indian health facilities including projects which combine IHS funds with other federal or non-federal funds.

Section 309 strengthens the existing statute which encourages the use of lease assignments (the tribe leases the facility to IHS and utilizes an assignment of lease rentals to amortize construction financing) by requiring that such leases be treated as "operating leases" under the Budget Enforcement Act. This would allow the lease costs to be scored over the term of the construction loan rather than all in the first year as is now the case.

Section 310 establishes a program of federal loans, loan guarantees, and grants for loan repayments to provide a new source of financial assistance for health facility construction. The Health Facilities Loan Fund under section 310 is described below.

Section 311 is expanded to allow tribal organizations (which are frequently health care providers under the ISDEAA) to lease facilities for health care services without advance approval in appropriations legislation. At present this authority is limited to tribes.

Section 312 expands an existing demonstration project to allow tribal organizations, as well as tribes, to enter into a joint venture with IHS under with the tribe or tribal organization provides the facility at no cost to IHS and IHS agrees to fund the services.

Section 317 authorizes IHS to accept funds from any sources, including federal and state agencies, for health facility construction and renovation and to enter into agreements with other federal agencies, state agencies, and other entities. Federal agencies are authorized to transfer funds for construction to the IHS.

Each of these provisions provides an additional alternative means of reducing the enormous backlog of health facility construction needs in Indian and Alaska Native communities. Perhaps the most valuable feature of these provisions is that they may be used in combination to create a viable financial package. A facility could be funded partly from a tribal loan from HHS, partly from a federally guaranteed private loan and (for tribes able to afford it) partly from a contribution of tribal funds. The facility could be leased in advance to IHS and the construction financing could be paid off from lease rentals.

IHS can presently document an Indian health facility construction need of over $1,000,000,000 and estimates a long-range requirement of over $3,000,000,000. Section 301 would require IHS to annually update the total Indian health facility construction need. At the present rate of construction with appropriated funds under the Indian Health Construction Priority System it will be many generations before Indian health care is provided throughout the United States in safe and reasonably adequate facilities. The absence of such facilities is dramatically in contrast to the goals of the Indian Health Care Improvement Act.

In response to question 4 regarding the revolving loan fund, I am please to report on this new mechanism that Northwest tribes have promoted over the past four years.

HEALTH FACILITY LOAN FUND

You have requested an explanation of the Health Care Facility Loan Fund, a new revolving fund which would be established under section 310 of the bill. The loan fund is intended to provide a source of facility funding for Indian and Alaska Native tribes which have no prospect of prompt construction under the Priority System and which lack adequate revenue or resources to provide tribal funding or borrow in the private sector for the total cost of needed health facility construction or renovation.

The details of how the fund would be administered would be provided in regulations developed by the Secretary with tribal involvement through negotiated rulemaking and subject to standards specified in section 310(b).

In some instances a financial package including a federal loan, a federal guarantee of a bank loan, together with lease rentals from a lease to IHS, will be a viable means of meeting with need without adding to the direct appropriations for construction. These methods would also permit the introduction of innovative design methodologies which IHS has hitherto resisted. While facilities should meet Joint Commission for the Accreditation of Health Organizations and Uniform Building Code Standards, cost could be reduced by avoiding more rigid standards imposed in IHS planning.

The larger the revolving fund the more it would be able to contribute to the reduction in the facility backlog, presently documented by IHS at over $1,000,000,000. We recommend a $100,000,000 revolving fund as a start, but even as little as $25,000,000 would provide a useful additional alternative for assisting in meeting the need.

In response to part A of question 4 regarding the award of scholarships to non-Indians, I know that the National Steering Committee agrees with you that the

purpose of this title is train American Indian and Alaska Native providers. We need to do all we can to make sure our recommended language accomplishes this goal. I have asked the National Steering Committee to take another look at the provisions in Title 1 of the proposed act.

Your related question in (B) about Indian Health Service policy favoring physicians was also reported to the National Steering Committee. I know that we too were concerned that a policy that favors physicians over other health professionals is not in the best interest of Indian people. I think the National Steering Committee should consider more specific language to accomplish the desired goal.

Thank you for the questions you have raised. I assure you that I have brought all these concerns to the attention of the Reauthorization Leadership Group of the National Steering Committee at a meeting in Albuquerque, New Mexico on July 12, 2000. They have asked me to prepare my response from the perspective of the National Steering Committee as a whole rather than as a response from the Northwest Portland Area Indian Health Board and our member tribes. I have agreed to do so and, in fact, believe that our answers would be no different if only our tribes were consulted.

I will provide you with follow-up to all your questions. Please contact me or Ed Fox, our Northwest Portland Area Indian Health Board staff person working on the Indian Health Care Improvement Act Reauthorization, at 503-228-4185.

Sincerely,

Julia A. Davis

Statement of Yvette Roubideaux MD MPH

President

Association of American Indian Physicians

Before the Senate Committee on Indian Affairs

On the Reauthorization of the Indian Health Care Improvement Act

May 10, 2000

Good Morning, Mr. Chairman and Members of the Committee. My name is Dr. Yvette Roubideaux, and I am the President of the Association of American Indian Physicians. I am a member of the Rosebud Sioux Tribe, and am a Harvard-trained, Board-certified Internist with experience working in the Indian health system. I am currently a Clinical Assistant Professor in both the College of Public Health and College of Medicine at the University of Arizona In Tucson AZ. I am honored and grateful for this opportunity to testify in support of the Reauthorization of the Indian Health Care Improvement Act (P.L. 94-437). On behalf of the Association of American Indian Physicians, I would like to thank you for the opportunity for our organization to provide testimony today.

I am proud and honored to be the President of the Association of American Indian Physicians, which I believe is now beginning to realize its role as a leader in improving the health of Indian communities. The Association of American Indian Physicians (AAIP) is a national non-profit organization located in Oklahoma City that was founded in 1971 by 13 Indian physicians. AAIP now has a diverse membership of approximately 300 American Indian and Alaska Native physicians from all regions of the country with expertise in many areas. The mission of the Association of American Indian Physicians is "to pursue excellence in Native American health care by promoting education in the medical disciplines, honoring traditional healing practices and restoring the balance of mind, body, and spirit." While the activities of the Association of American Indian Physicians focused for many years on the recruitment and retention of Indian students in the health professions, now that we have a critical mass of members we are expanding our programs to include more education on Indian health issues, Indian health program development, and education on Indian health policy issues. We now have the capacity to be a significant resource for tribes, Indian communities and other organizations and groups such as the Senate Committee on Indian Affairs. We are grateful for the opportunity to provide input today because many of our members have seen first hand the health problems and challenges in Indian communities, and the pressing need for more resources and efforts in all areas of Indian health.

Despite being trained at the best medical school and residency program in the country, I faced significant sadness and frustration at my inability to provide quality health care to my patients when I worked in the Indian Health Service due to the severe lack of resources, outdated equipment and facilities, and shortages of high quality health care providers and staff. Many of our members struggle to provide quality health care despite these obstacles, but sadly, many also suffer significant symptoms of burn out and decide to leave the Indian health care system. While the Association of American Indian Physicians has approximately 300 members, and approximately 200 of these members have practiced medicine in the Indian health system at one time, only 69 of our members currently work in Indian health system. Currently, a total of 852 full time physicians of all races work in the Indian health system. Many of our members who leave the Indian health system are disappointed about the generally poor working conditions, lack of resources, and lack of recruitment or retention efforts to keep them in the system. While not all Indian physicians who graduate from medical school want to work in Indian health, there should be more efforts to recruit and retain American Indian health professionals with an interest in working in the Indian health system. Sadly, according to 1990 Census data, American Indians are the most under-represented minority in the physician category, with only 48/physicians/100,000 population, compared to other racial categories and the overall total (236 physicians/100,000 population).

We support Reauthorization of the Indian Health Care Improvement Act and its reaffirmation of the federal trust responsibility to provide health care for American Indians and Alaska Natives, and the sovereign rights of tribes to self-determination and self-governance. We support the goal of the United States to raise the health status of Indians to the highest possible level and believe that American Indians and Alaska Natives deserve the highest quality of health care. We also believe that American Indians and Alaska Natives deserve the opportunity to receive medical care from well-trained, culturally competent American Indian and Alaska Native health professionals. The major focus of our testimony today will be on Title I – Indian Health Human Resources and Development.

We are grateful for the Indian Health Service Scholarship program, authorized under the Indian Health Care Improvement Act. I would not be sitting here today as a physician without the support that I received under Sections 103 and 104 of Public Law 93-437. However, more funding and administrative support is needed for the scholarship program. Under Title I, the various components of the scholarship program have been amended to broaden the scope of health professions covered, allocate resources, decision-making and priority setting to the Areas, and require payback of scholarship obligations within the Area from which the scholarship was awarded. While we agree that the scholarship program should be more responsive to local priorities and needs, and are supportive of more local participation, we are not supportive of further

restrictions on the location of the payback obligations for these scholarship recipients. Placing more restrictions on the placement of Indian health professionals for their payback positions will further demoralize them, worsen efforts at recruitment and retention, and potentially result in placement of health professionals in facilities or positions that do not match their qualifications or career needs. Currently, scholarship recipients are allowed to payback their obligations in areas where there are shortages of staff or on their own reservations. We strongly recommend that the current rules should be retained and that language that restricts payback to the specific Area from which the scholarship is received should be changed. The language that says "...for special circumstances a recipient may be placed in a different Service Area..." is not strong enough and does not guarantee appropriate placement for these recipients. We also believe that scholarship recipients should be eligible for the Loan Repayment Program and any available recruitment and retention bonuses. We also agree with clarifying that scholarships and repayment of loans are "non-taxable," and to ensure culturally competent care, we support the requirement for training new health professionals in the culture and history of the tribes they will serve.

While most of our comments today were limited to Title I of the Indian Health Care Improvement Act, we also would like to briefly comment on the other Titles in the Act. In Title II, Section 204, we support continued funding of the current model diabetes programs and programs funded under the Special Grants for Diabetes Program created under the Balanced Budget Act of 1997. Funding for these programs must be continued through 2012 as the problem of diabetes in American Indian communities is reaching epidemic proportions and more resources and programs are needed to fight this growing problem. In addition, we support retaining language to fund at least one Area Diabetes Consultant (formerly known as diabetes control officers) for each Service Area and disagree with current language to retain these positions at the discretion of each Area. We also support expansion of screening for all cancers in Section 207, and funding of tribal epidemiology centers in all Areas as stated in Section 209.

We support all provisions in Title III that would allow the construction of high quality state of the art health care facilities for all Indian communities as soon as possible. In Title IV, we support maximizing reimbursement for services from all third party sources, and we support protecting the opportunity of Indian people to receive health care in culturally competent Indian health programs rather than being assigned to unfamilar, distant managed care organizations. In Title V, we support the recommendations and changes for Urban Indian programs, primarily because these programs are severely under-funded despite being the primary source of health care for a large proportion of the American Indian and Alaska Native population. While we recognize and respect the government-to-government relationship of the tribes with the federal government, we also support finding mechanisms to help fund and support Urban Indian programs to address the health needs of tribal members in urban areas.

We strongly agree with the recommendation in Title VI that the Director of the Indian Health Service be elevated to an Assistant Secretary for Indian Health and that this be incorporated into the Indian Health Care Improvement Act if similar legislation is not passed. We also strongly recommend that the position of the Director of the Indian Health Service should continue to be filled by an American Indian or Alaska Native physician. In Title VII, we support the recommendations for behavioral health and increased funding and support in this area. In Title VIII, we are supportive of the establishment of a National Bi-Partisan Commission on Indian Health Care Entitlement to examine the establishment of an entitlement provision for Indian health services. We would like to recommend that a representative from the Association of American Indian Physicians be appointed to serve on this Commission, as our members are knowledgeable about health care services for Indians and can serve as a resource for this Commission.

On behalf of the Association of American Indian Physicians, I would again like to thank the Senate Committee on Indian Affairs for the opportunity to provide testimony at today's hearing on the Reauthorization of the Indian Health Care Improvement Act. Our organization is available as a resource to your Committee and the tribes and Indian organizations involved in this process, and I encourage you to call upon us again for any assistance. We are grateful for the opportunity to support the Reauthorization of the Indian Health Care Improvement Act, and encourage your efforts to help achieve reauthorization as soon as possible. Thank you.

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June 16, 2000

Ben Nighthorse Campbell, Chairman
United States Senate Committee on Indian Affairs
Washington DC 20510-6450

Mr. Chairman,

I am writing to answer your follow-up questions in response to my testimony at the May 10th hearing on the Reauthorization of the Indian Health Care Improvement Act. I am grateful for the opportunity to respond and to help clarify these issues in writing, and thank you for allowing the Association of American Indian Physicians to provide input on this important legislation. My answers to each question are as follows:

1. What can we do to attract more American Indians and Alaska Natives into health professions?

I believe it is possible to attract more American Indians and Alaska Natives (AIAN) into the health professions through 3 strategies:

1) creating opportunities for young students to see that other AIANs have successfully entered the health professions (role modeling)
2) developing more opportunities for students interested in the health professions to learn how to successfully prepare for these careers (mentoring)
3) identify more resources to financially assist students as they pursue careers in the health professions (scholarships/loans)

In terms of the first strategy, AIAN students often do not consider health professions because they cannot picture themselves in this role due to a lack of AIAN role models. With the shortages of AIAN in the health professions, students often do not get the chance to see many AIAN health professionals, and therefore do not realize that they could enter these careers. Students also need to see these role models early in life in order to influence their future career choices and to help focus their studies in science and math. For example, the Association of American Indian Physician conducts a summer program every year called the "National Native American Youth Initiative" in which 50 high school juniors and seniors are introduced to the health professions by AIAN

physician role models. More funding is needed for programs for young students to help them see AIAN role models who serve as evidence that they can choose to enter the health professions.

With regard to the second strategy, AIAN students interested in health careers need to learn the steps they must follow to successfully enter the health professions. Because there is a lack of AIAN role models, students often have difficulty finding health professionals who can mentor them and help assist them during their training. Often AIAN students are at a disadvantage compared to other students whose mothers or fathers are health professionals and who can help their children learn the steps to enter these careers. Many AIAN students are the first individuals in their family to attempt to have a career in the health professions, or even are the first person in their family to go to college. Workshops and training sessions are needed for AIAN students to help them learn what steps they need to take to successfully enter the health professions. For example, the Association of American Indian Physicians conducts a number of "Pre-Admission Workshops" for AIAN students who are in their pre-med courses to help them learn how to successfully apply to medical school, write their application essays, and prepare for their interviews. During these workshops, AIAN physicians talk with the students about their experiences and give advice on how to overcome barriers.

The third strategy addresses the issue of the high cost of health professional education and the difficulty that AIAN students have in finding ways to pay for medical school or health professional training. Since over a third of AIAN live under the poverty level, many families can barely afford to live and cannot contribute to helping their children attend college or training. In addition, financial aid programs at colleges routinely expect significant family financial contributions, which many AIAN families cannot meet. The Indian Health Service Scholarship program has helped many students enter the health professions who otherwise would not have been able to afford to go to college or medical school, and has been very successful at increasing the numbers of AIAN health professionals. However, more funding is needed, as each year there are many applicants who cannot receive funding due to budget limitations. We recommend that the funding for this program be increased as much as possible, so that more students can have the opportunity to enter the health professions.

2. **Your testimony indicates that the requirement that scholarship recipients serve in the area that funds their scholarship should be removed. Yet rural tribes continuously report a shortage of health professionals. How do we address those needs if we follow your recommendations to remove the requirement that the people who are trained with IHS money serve in the area that funded them?**

Actually, the current scholarship program does not require recipients to pay back in the specific area that funded them since the program is administered

nationally. The NEW language in the draft legislation adds the requirement that students pay back to the specific area that funds them. We are recommending that the current payback requirements are retained and that the new language is NOT adopted.

I must clarify that I think that the Indian Health Service Scholarship Program is a wonderful program that has enabled many AIANs to enter the health professions. The CURRENT payback rules allow AIANs to payback their scholarship obligations in areas of "high need" and they can choose from sites identified by the IHS Scholarship Program. These sites include health programs and facilities around the country that have had problems in filling their vacancies. They are not limited to particular areas of the country in the current program.

In the NEW draft legislation developed through the tribal consultation process, the IHS Scholarship Program was changed to allow more local control of the program. In the new language, much of the administrative functions of the scholarship program are transferred to the IHS Areas, including priority setting, selection of recipients, and control of funding. However, in this new language, the payback requirement was changed from the current practice of allowing students to choose from identified sites around the country to a strict limitation of the payback to the specific area from which the scholarship funding was received. We are opposed to this NEW language that limits payback to one specific Area. We do believe that recipients should payback their obligations in high need areas, but should be allowed to choose from sites in more than one area. Not only does retaining choice in payback sites help with retention, it also ensures that the recipient is matched well to the site so that the highest quality of care can be provided for Indian people. Pediatricians should be allowed to payback their scholarships in sites with positions for pediatricians, and Internal Medicine physicians should be allowed to payback their scholarships in sites with positions for Internal Medicine physicians. Limitations on payback sites in one area only create the possibilities of physicians being forced to payback at sites that do not have appropriate positions for their training, thus jeopardizing the care of Indian people. The scholarship program must RETAIN its current payback system that allows recipients to choose from identified high need sites in all areas, and these choices should not be limited to one area.

So for example, I was a scholarship recipient from the Aberdeen Area. When I was ready to begin my payback, I received a list of "high need" sites in all of the 12 IHS Areas, and was allowed to pick from this list for my payback site. At that time, there were no sites in the Aberdeen Area that were appropriate for my specialty (Internal Medicine), so I picked a site in the Phoenix Area that allowed me to focus on Internal Medicine. I was happy at this site, was able to use my skills, and have remained working in the Indian health field ever since. That particular site was one of the highest need sites in the country, and I helped fill a vacancy that had gone unfilled for several years. The position was appropriate for my skills, so I was able to provide high quality care for the Indian people that I

served. However, if I were forced to payback at a site in Aberdeen, it is likely that I would have had to practice outside of my training which would have significantly put patients at risk, and may have adversely affected my happiness and retention at that site or in the Indian health system in general.

Therefore, while we are supportive of more local control of the scholarship program, we are not supportive of the new requirement that recipients payback only in one area. We believe that the current payback requirements should be continued, and that new language in the legislation that restricts payback to one area be removed. By making the scholarship program more flexible and attractive, we will encourage more students to apply for it and this will increase the pool of health professionals available to work in the highest need sites in the Indian health care system. The best way to attract health professionals to work in areas of high need are to create positive incentives to help recruit and retain them, not to place more restrictions on them and force them to go to places that they do not want to go. I think every IHS scholarship recipient understands that they need to payback their scholarship in an area of high need; retaining the ability to choose which high need site will help ensure the highest quality of health care for AIAN people. Please retain the current payback system, and do not adopt the new language in the draft reauthorization bill.

3. If scholarship funds are not adequate to cover the cost of medical school, what technically prevents scholarship recipients from also receiving loan repayment funds?

The Indian Health Service will not allow an IHS scholarship recipient to receive loan repayment during the time they are repaying their IHS scholarship. They will also not allow AIAN who are in IHS scholarship payback status to receive recruitment and retention bonuses. Their logic is that they are already receiving a bonus, since they are in payback status. However, this system creates a hardship for AIANs since the scholarship funds often do not cover all of the costs of medical school. I had to take out additional loans each year just to survive, as the stipend only covered part of my living expenses. So, while I was in payback status for my IHS scholarship, I also had to use my salary to pay back my loans. The other non-Indian physicians I worked with were eligible for loan repayment, so while we made the same base salary, they got their loans repaid, whereas I has to use my salary to make my loan payments. Many AIAN physicians believe that this restriction creates a "second class" system where the AIAN physicians on payback status actually make less total salary than the non-Indian physicians who are eligible for bonuses and loan repayment. This adversely affects the retention of the AIAN physicians, who become frustrated as they watch their colleagues receive loan repayment and therefore have a higher salary. I believe that the language in the Indian Health Care Improvement Act creates this limitation, and that a simple change in wording could allow AIAN physicians in payback status for the IHS scholarship to be eligible for loan payment and

recruitment/retention bonuses also. We believe that this would help in recruitment and retention efforts enormously for the Indian health system.

4. You have recommended that the position of area diabetes officers, previously required in the act but dropped in this draft, be retained. Why do you think this is important?

Area diabetes officers, or Area diabetes consultants as they are referred to now, have served a critically important function in the Indian health care system since the creation of the Indian Health Service Diabetes Program in the 1970s. Area diabetes officers help coordinate diabetes related activities in each area, and serve as a regional resource for technical assistance for all the programs in the area. In addition, the Area diabetes officers now also serve as project officers for the Special Diabetes Grants for Indians Program created under the Balanced Budget Act of 1997. Their role has never been more important than now as many tribes and Indian health programs have requested more technical assistance as they develop their new diabetes programs with their grant funding. The new language in the draft changes these positions to be at the discretion of the Areas. This creates the possibility that some areas may choose to discontinue this position and allocate funding elsewhere. However, this would be detrimental as it would destroy a critical position in the network of diabetes resources in the Indian health system and local programs would no longer have access to technical assistance, which they have clearly stated that they are in need of during a series of regional meetings held by the Indian Health Service Diabetes Program this year. We recommend that the language that requires Area diabetes officers in each area be retained to ensure that this resource continues to be available to local programs in all areas.

5. Diabetes continues to increase among American Indians and Alaska Natives at an alarming rate. As a medical doctor, what do you think needs to be done to curtail the incidence of diabetes?

Diabetes is a serious, growing problem for AIAN communities. While there were rare case reports of diabetes in the early 20th century, we have entered the 21st century with some AIAN communities experiencing the highest rates of diabetes in the world. This alarming increase of diabetes is due to the dramatic changes in the lifestyles of AIAN, including a more western high fat, high calorie diet and less physical activity, all resulting in alarming rates of obesity. These changes in diet and lifestyle have taken AIANs away from their more healthy traditional lifestyles of the past. AIANs did not have diabetes as a problem 100 years ago because they lived a healthy lifestyle that promoted wellness and prevention. Now, the lifestyles of AIANs have changed in ways that have adversely affected their health.

There have been many advances in the medical research on diabetes, and several studies are now beginning to suggest that diabetes can be prevented in

those at risk for this disease through healthy diet and regular exercise. Therefore, strategies to address the rising rates of diabetes need to focus on helping AIAN communities learn to be healthy again. This includes the need for more education about diabetes, its risk factors, and how to prevent it, as well as education on how to eat healthy and exercise. In some communities, combining this education with lessons from our past traditions can help increase the acceptability of this education to AIANs. In addition, these messages about healthy diet and exercise need to be taught to AIAN people throughout their lives, including education for young children while they are in school.

The Special Diabetes Grants for Indians Program is an example of what we can do to help in the fight against diabetes. As a result of this $150 million grant program, 333 new IHS, tribal, and urban diabetes programs have been created in AIAN communities, and many of them focus on the prevention of diabetes in their communities through education. This grant program has provided funding for prevention and treatment services throughout the Indian health system, and the recent Interim Report to Congress from the Indian Health Service Diabetes Program details the variety of programs that have been implemented. However, based on the series of regional meetings by the IHS Diabetes Program, more funding is needed, especially for technical assistance in program evaluation, data/epidemiology, and program development. The funding for this program should be continued and increased markedly if possible. Doubling or tripling the funding will help but will still not meet the incredible need for prevention and treatment services in the Indian health system.

However, there is still a great need for more research to determine the best strategies to address the problems of diabetes in AIAN communities. While there is plenty of research on what works in the general population, there is little research available in the medical literature on what works in the AIAN population. Actually, much more funding is need to encourage "translation" of current research results into practice in AIAN communities. For example, the diabetes community in the U.S. recently celebrated the findings of the UKPDS study, which finally showed that the complications of diabetes can be prevented through intensive control of blood glucose. However, it is not clear how these findings can be translated into the care of AIANs. For example, in order to achieve the great reductions in complications, intensive education of each patient needs to occur with close follow-up by providers. As you are aware, the Indian health system is faced with a shortage of health care professionals and funding, and it is likely that it will be difficult for Indian health programs to provide the level of care that can reduce complications. More funding is needed for research to determine the best way to implement the findings of this important research as soon as possible to help AIAN with diabetes prevent complications. Another area where more research is needed is the behavioral and mental health effects of diabetes. We enthusiastically support your previous recommendation to establish additional diabetes prevention and research centers in the country to help address the problem of diabetes in AIAN communities.

6. Why do American Indians and Alaska Native suffer so many serious health deficiencies – is it genetic, environmental, or is there a combination of reasons?

A number of factors influence the health of a population, including genetics and a number of environmental factors which include lifestyle and behavioral factors, environmental and toxic exposures, and all of the health effects of poverty and lower socioeconomic status. In addition, the significant disruption of the social capital of AIAN communities with the loss of traditional ways has also disrupted those systems that were in place to promote health and prevent disease. I often teach about public health issues and always try to make the point that AIAN communities had the first primary care, prevention-oriented, public health systems of health care prior to contact by Western civilizations. There are plenty of studies in the public health literature about how the health status of populations and communities depends to a significant extent on how successful their communities are in terms of socioeconomic status and in terms of human capital and social support.

Therefore, the health of AIANs depends on the health of the communities in which they live, and because a number of factors influence health, all efforts to address these factors and help restore wellness, health, economic and politic success to AIAN communities will help improve the health of AIANs. More funding is needed to study these factors and how they contribute to the health of AIAN communities, with guidance from the studies that have been done in the general population.

In terms of the federal trust responsibility, a significant proportion of the health problems that AIAN suffer from is related to the dramatic under-funding for Indian health care. Health disparities still exist, and well as disparities in the quality of and access to health care for AIANs. I found practicing medicine in the Indian Health Service very frustrating because I could not provide the same level of health care to my patients as I did when I was a medical student and resident at Harvard. Our facility was lacking basic, updated equipment, and subspecialty care was two hours away. While I believe that there are many dedicated health care providers working in the IHS, I also know that they can't provide the very best care for AIANs due to the limitations in funding for Indian health care. There is clearly a need for more funding to provide health care services to AIANs to provide them with the highest quality of health care possible.

7. What type of role do you think traditional healing has in modern medical practice?

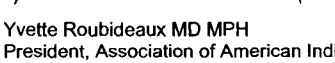
Traditional medicine clearly has a very important role in the care of AIAN patients. Many AIAN still use traditional medicine as a source of health care, and for some of them it is their primary source of health care. The Association of

American Indian Physicians includes in its mission statement its wish to help promote traditional medicine practices, and provides education on traditional Indian medicine for health care providers and students. Many of our members believe that health care providers should work more closely with traditional healers and partner with them in the care of AIAN patients. Many view traditional healers in a similar role as other sub-specialists with which they consult, and honor the wishes of patients who want to include traditional medicine as a part of their health care. While not all AIAN use traditional medicine, we believe it should be respected as a valid option in the health care of AIAN patients who request it. Indian health care programs should include an orientation on the local customs and traditions of its population for new health care professionals, and an understanding of the importance of traditional medicine in the lives of the people from the community served. In addition, health care providers must understand potential interactions and side effects of traditional medicines in order to understand the effects of these medicines on their patients, and to avoid any adverse drug interactions.

The Association of American Indian Physicians offers workshops on traditional medicine for health care providers, and is willing to offer them to Indian health programs as a method of orientation of their health care providers to traditional medicine. Our only limitation to offering this training is the cost of transportation of our members and traditional healers to teach at programs around the country. We therefore support more funding for education and orientation on traditional medicine and the important potential role it plays in the care of AIAN individuals. In order to provide the highest quality of health care to AIAN patients, health care providers need to understand the role of traditional Indian medicine and how they can respectfully partner with traditional healers in their community.

Thank you for the opportunity to respond to your questions related to my testimony on May 10, 2000. If you have any further questions on the answers to your questions, feel free to contact me.

Sincerely,



Yvette Roubideaux MD MPH
President, Association of American Indian Physicians
Clinical Assistant Professor, College of Public Health
University of Arizona

Testimony of the Quentin N. Burdick Indian Health Program

before the United States Senate Committee on Indian Affairs

May 10, 2000

Good Morning Mr. Chairman and members of the Committee, I am Barbara Dahlen, MS, RN, FNP, Assistant Coordinator of the Recruitment and Retention of American Indians into Nursing (RAIN) Program which comes under the Quentin N. Burdick Indian Health Programs at the University of North Dakota. The three programs include INMED (Indians into Medicine Program), RAIN and INPSYDE (Indians into Psychology Doctoral Education Program). I am an enrolled member of the Turtle Mountain Chippewa who resides in Belcourt, North Dakota. I would like to thank you for the opportunity to address the re-authorization of the Indian Health Care Improvement Act.

A partnership was created when the Congress of the United States gave the three programs at UND the mission of helping alleviate the shortage of American Indian health professionals. The programs created and supported through the Quentin N. Burdick Indian Health Programs, INMED, RAIN, and INPSYDE have created educational opportunities for Indian students that would not have existed otherwise. Equally important, these programs have developed partnerships with Tribal Colleges and Tribal officials, with various aspects of the university and other agencies and projects to enhance the opportunities and strengthen the educational base to promote success of students recruited to these programs.

The programs at the University of North Dakota have proven themselves to be very successful as the data we are providing will show. An issue that impacts greatly upon the ability of these programs to continue this record is the fact that funding to the programs has been decreased significantly - in real dollars, not just by inflation. Recruiting and retaining students is an intensive process.

The programs have been excellent stewards of the funds they have received. The impact of these funds is far greater than just upon the students in the programs. Partnerships developed with Tribal Colleges have helped these colleges build up their courses to strengthen the preparation of students transferring to senior universities. This has been done with Tribal Colleges at Fort Totten, ND, Fort Peck, MT, and Fort Berthold, ND. Such efforts support all students who attend these colleges and help the colleges meet regional accreditation standards, thus facilitating transfer of courses to other colleges and recognition of individual college programs. Another example, of partnering is the partnership with Sisseton-Wahpeton Tribal College. Nursing students from UND for whom the ladder approach to the baccalaureate degree in nursing is the most appropriate strategy transfer to Sisseton-Wahpeton then upon completion of that program and passage of the licensing examination, return to UND to complete the baccalaureate component. Partnerships with local scholarship programs such as Transcends and the UND tuition waiver program further stretch available resources.

These programs are successful. They are cost-effective. They provide opportunities for Indian students. They are beneficial to Indian Country. We thank you for the opportunity to present to the committee these success stories, and request that the programs continue within this legislation so that these successes can be multiplied.

INMED

The Indians into medicine program (INMED) is an academic support program directed to address the substandard health conditions that exist in American Indian communities by increasing the number of American Indian health professionals that serve these communities. INMED, at the University of North Dakota School of Medicine, has been in operation since 1973 and has graduated approximately one-fifth of the Indian medical doctors in the United States who are enrolled members of federally recognized tribes. In addition, the program has academically assisted and graduated nursing and allied health care professionals.

The program is located where health care professional needs are the greatest, and INMED maintains an affiliation with the 24 reservations in North Dakota, South Dakota, Montana, Wyoming and Nebraska. Representatives from each of these Indian reservations are appointed by their respective tribal governments to serve on the INMED Tribal Board. These representatives are instrumental in the development of Program policy and assure that INMED continues to be a significant resource that address's their health care needs. This Board also serves as an important linkage for student recruitment and placement, and maintaining responsiveness to the Indian community.

INMED has made an impact. As of this year the program will have graduated a total of 122 medical doctors and 115 nursing and allied health care professionals. Approximately 85% of INMED's graduates have used their training to provide direct health care services to American Indian populations, or they are obligated to future scholarship service paybacks pending completion of residency programs and/or placement at Indian health priority need areas.

INMED offers educational support for students from the elementary through professional school levels. This comprehensive approach distinguishes INMED from most other educational assistance programs. Over 110 students each year participate in INMED's academic year support program. Another 100 students attend INMED's annual summer enrichment sessions at the junior high, senior high and medical preparatory levels. These summer programs bolster participants' math and science backgrounds, introduce them to health careers and provide INMED with a constant pool of applicants for college level programs.

INMED is fully institutionalized within the UND School of Medicine. The program has department status, and an entire wing of the Medical School North Unit building (6615 sq. ft.) has been allotted for INMED offices, library, study areas, and seminar room. A Medical School Advisory Committee of seven faculty members oversees INMED activities.

INMED has also involved itself in creating formal partnerships with other educational systems to create educational opportunities for American Indian students. One of these arrangements is a cooperative program with the University of South Dakota School of Medicine. An INMED Satellite Office at USD began operation in 1990. The USD office assists in the recruitment of Indian students in South Dakota and operates an Indian student support program at the campus in Sioux Falls. Up to two University of North Dakota INMED medical students transfer each year to South Dakota to complete their third- and forth-year of medical training.

In addition to this partnership, INMED has formally involved itself in a partnership with White Earth Community College, Leech Lake Community College and Northwest Technical College in Minnesota.

Under this agreement, Indian students are recruited from the White Earth, Leech Lake and Red Lake Indian Reservations into a pre-medical / clinical lab science curriculum. The student will attend the first year of college at White Earth or Leech Lake and then transfer to Northwest Technical College in East Grand Forks, Minnesota to complete the second year of education. The student will then transfer to the University of North Dakota for the final two years of undergraduate education. Upon graduation, the student will be qualified to begin a professional career as a clinical lab scientist (medical technologist) or continue on to medical school.

INMED has also recently submitted a proposal to enter into a formal partnership with Oglala Lakota College on the Pine Ridge Indian Reservation of South Dakota. If this proposal is sponsored, INMED, in cooperation with Oglala Lakota College, will conduct academic activities in the K-12 school system on the Pine Ridge Reservation. Students will then been recruited to Oglala Community College for their first two years of pre-medicine and then transfer to the University of North Dakota to complete their premedical bachelor's degree.

Finally, INMED has just recently entered into a formal relationship with the Mayo Clinic. Under this arrangement, INMED medical students will be afforded the opportunity to participate in ongoing cancer research at the Mayo Clinic. The physician responsible at the MAYO Clinic for this research is herself a graduate of the Indians into Medicine Program, Dr. Judith Salmon Kaur.

In summary, INMED is a successful program that has been emulated internationally. We have been extremely successful in training qualified American Indians in not only medicine but in a variety of allied health fields including physical therapy, clinical lab science, medical social work, counseling psychology, nursing, and dietetics. To date, 237 American Indians have obtained their professional degrees with the assistance of INMED. The INMED Program, however, goes far beyond the typical concept of training health care professionals. We enroll, retain and graduate students in support roles necessary to operate a health care facility such as in records management, business administration, medical social work, computer science and civil engineering.

INMED successfully enables Indian students to establish academic and personal readiness for college and medical school. The program enrolls these students in the proper curricula, and provides valuable support services which results in qualified health care professionals to address the serious health care issues facing American Indian people.

RAIN

- In 1990, RAIN was one of the four original funded Sec. 112 nursing grants. The four programs were UND, Salish Kootenai College, Arizona State University and SUNY- Buffalo. Since that time five other programs were funded of which two have been discontinued. The intent of the law was to increase the number of nurses at the baccalaureate and masters levels prepared to provide health care to Indian people.
  In order to depict the success of the RAIN program at the University of North Dakota, qualitative and quantitative will be provided:

- **Quantitative Data**

  ✓ **1948-1990**, University of North Dakota College of Nursing established; 42 students

admitted; 18 American Indian (AI) students graduate with BSN; no AI nurses admitted to graduate nursing program

- ✓ **Fall 1990-Spring 2000**, RAIN Program established; **100th** AI student admitted to CON (total of 142); graduated 70 AI BSN students (total of 88).
- ✓ **Fall 1992-Spring 2000**, 16 AI nurses have graduated with master's degrees in nursing. **Currently,** 8 enrolled in the graduate nursing courses, 25 students enrolled in nursing curriculum, and 10 pre-nursing students

- ✓ Most significant is the decrease in attrition rate seen with the RAIN Program. Prior to the program being established, the attrition rate was about 20 percent. Currently, attrition is at 7 percent.

- **Graduates work in Indian Country**
  - ✓ 90% of BSN graduates work in Indian Country
  - ✓ 93% of master's graduates work in Indian Country
  - ✓ 1990 vacancy rate at Belcourt IHS facility was 63%, now 20 RAIN graduates, including 5 master's prepared nurses are there
  - ✓ 7 Directors or Assistant Directors of nurses at several IHS facilities
  - ✓ 4 Faculty positions in Minnesota, North Dakota, South Dakota
  - ✓ Chief nurse consultant, Aberdeen Area IHS
  - ✓ Women's health consultant, Aberdeen Area IHS
  - ✓ 2 family nurse practitioners

- **Graduates are academically successful**
  - ✓ Completed doctoral education (one of 15 doctorally prepared Indian nurses in US)
  - ✓ Entered and completed master's education

- **Program elements**
  - ✓ Scholarships and financial aid assistance. All students have had some sort of assistance - IHS, RAIN, UND tuition waivers, foundation grants, etc.
  - ✓ Accepting and supportive environment to promote a sense of belonging
  - ✓ Indian nurse mentors
  - ✓ Close academic monitoring and aggressive advisement
  - ✓ Open door policy
  - ✓ Value clarification
  - ✓ Cultural awareness of college faculty and students
  - ✓ Indian staff and professional role models

- **Cooperative activities**
  - ✓ Work with Tribal Colleges to improve pre-nursing courses to enhance transferability and student success at UND
  - ✓ Partnering with Sisseton-Wahpeton Tribal College for nursing career mobility

- **Qualitative Data**: Personal Vignettes

Retaining the students after recruiting them is very labor intensive. It involves a comprehensive 24 hour open door policy. It means creating a sense of belongingness within the College of Nursing. It involves creating a feeling of extended family. It involves valuing the diversity that the students bring with them,

and giving unconditional acceptance. Retention involves believing in increments of success. It means being involved in all aspects of their lives. RAIN becomes their home away from home. Below are personal stories that reflect how students feel about the RAIN Program.

1992 BSN, Turtle Mountain Chippewa. Prior to the start of RAIN, I struggled in every class. I had no support system other than two fellow nursing students. RAIN staff encouraged me to seek help at Learning Services after I realized I was having difficulty reading. Through testing , I learned I was dyslexic. Now, I could approach learning in a different way. In addition, the RAIN nurse mentor would come to my home and help me prepare for all my nursing exams. I was a senior nursing student by the time that I first received an "A" in a nursing course. I never believed that was possible. I went on to graduate and passed boards. I am successfully employed with IHS as a charge nurse. I believe without the assistance of RAIN this would not have been possible. They helped me to reach my dream.

1998 BSN, MS student, Oneida/Sisseton Wahpeton. I started out as a participant in the INMED summer institute while in high school. I started at UND, as a new freshman. Due to immaturity, I left school married and had two children. Some years later when I returned to school, I chose to attend College in Havre, MT. I had very little support from the nursing program and failed an adult health nursing course. I contacted the RAIN Program about transferring back to UND. I was admitted in the spring semester to the CON and moved my family to Grand Forks. I struggled with personal problems which caused me to take an LOA from the CON. During this time, the RAIN staff remained in contact with me, and monitored my progress for my return to school. I was away from school for a year and a half when I returned to school to complete my BSN program. I graduated in the spring of 98 and was admitted into graduate school in the Rural health nursing track. Through all my struggles, the RAIN staff never gave up on me. They never gave up on me, even when I gave up on myself. They supported me unconditionally.

1996 BSN, Standing Rock/Crow. While I was a pre-nursing student at UND, I did not have enough money to return to school to pay for my room and board and pay tuition and fees. I remember contacting Deb Wilson and telling her through tears that I wanted to come back but could not afford housing. She told me that I could stay with her and her family. I spent a semester at her home rent free. I earned enough money working part time and going to school to find an apartment with a friend the next semester. Without Deb's intervention, I have no idea where life would have taken me. After I was admitted to nursing, I became pregnant with my first child and had serious complications. RAIN arranged for the instructor of one of my nursing courses to teach one on one during the summer session to keep me on track. I am currently working with IHS on my home reservation. I feel without the support and commitment from RAIN, I would have never graduated. They continue to keep in touch with me and stop in at the hospital to visit when they are out recruiting. My future plan is to return to school to become a family nurse practitioner. I plan on returning to UND and the RAIN Program because of the support services they provide.

1992 BSN, 1995 MS, Three Affiliated Tribes. When RAIN began, I had been on an LOA from the CON. I had two children and was procrastinating. I knew I needed to finish my pharmacology in order to return to my nursing program. I would not have completed the program without the constant prodding of RAIN staff. When I returned to school that fall, the RAIN Program was new to me. I never dreamed of the intensity of services that the program would provide. One Christmas, we were so hard up for money that I new I would not be able to provide any gifts for my children. Deb and Barb showed up at my door with gifts and food. They showed me their commitment to student retention. This act and many others gave me the courage to stay and complete the master's program in rural health nursing.. I am very proud to say I am a RAIN graduate. I am currently working at an IHS facility in Minnesota

1994 BSN, Wind River Arapahoe. When the College of Nursing started the RAIN program I was on an LOA and was contacted during the summer by Barb Dahlen about returning to school. I knew that this would be impossible because I had a huge accounts receivable bill at the university. RAIN worked the entire summer to arrange a payment program that would ensure the University would recover the money owed. With this agreement I returned to school and finished my nursing program. This would not have been possible without the support of RAIN.

1995 BSN, 1998 MS, Turtle Mountain Chippewa. Prior to pursuing nursing as a career choice I was in construction work as a laborer and roofer. I worked long hard hours and the future was not very bright. I am a single father of four children and I knew that supporting them would take a career change. I have two sisters who were in the nursing program through the RAIN Program. They felt I would make an excellent nurse so I contacted the RAIN Program. My two sisters both went on to complete their MS degree through the RAIN Program. I was admitted to the program and received great support. I was successful in completing the program but when it came to the RN NCLEX examination I had difficulty and consequently failed 4 times—Through RAIN support it was identified that I had severe anxiety so they arranged for me to take a therapeutic relaxation independent course with a faculty member and see a doctor and be put on an anti-anxiety medication 1 month prior to boards—I passed with flying colors—only the continued support I received allowed me to believe that I could pass. I have since gone on to complete the master's program and I am the supervisor of the clinic at an IHS facility in North Dakota.

2002 BSN, Crow. I am a sophomore nursing student who moved to North Dakota because of the recruitment efforts of the RAIN Program. This past semester has been very stressful due to the two deaths I had in my family which required me to return to Crow. During the last trip my car engine gave out. My uncle gave me a ride back to UND with my two children. I needed a vehicle to get my child to school and my son to daycare so that I could attend clinicals at the hospital at 6:30 in the morning. The RAIN staff was able to locate a used vehicle that I call the "Titanic". At their own expense they went to Fargo and picked up the vehicle. They arranged a small loan of $350 to purchase it. I do not have to start re-paying the loan until my financial situation is secure. The two times I had to return home, RAIN staff gave me money out of their own pockets to travel. They have been there for me and my family every step of the way. I know I can count on them.

Spring 2000 AD-RN, Turtle Mountain Chippewa. I was a junior second semester nursing student in the CON program when the courses became more difficult. I did not feel I could continue in the nursing program and be successful. RAIN staff discussed with me more options for continuing in nursing. I was informed that the previous semester they had formed a partnership with the Sisseton Wahpeton Community College AD-RN program. The RAIN program stressed their increments of success philosophy. The partnership has allowed me to transfer and work on completing the two year RN program. I know I would have failed out or dropped out if it was not for the RAIN Program. I still have the option of returning to UND in the future to work towards a BSN if I should choose.

Spring 2000 AD-RN, Spirit Lake Sioux. I will be the first RN from my reservation. I have been a participant of the RAIN Program since the summer of 1995. I came in as a pre-nursing student. I went as far as a first semester senior nursing at UND. Due to many personal problems, high anxiety and panic attacks, I withdrew from UND to pursue the AD-RN program at Sisseton Wahpeton Community College. Over the years, I have given the RAIN staff many reasons to give up on me, but they **never** have. They continue to call me and knock at my door with options to be successful. They have bought my groceries, bought gas for my car, helped me buy a car, and these are only a few of the many examples that I could tell you about. I could fill pages and not be able to show the gratitude I have for the women of RAIN.

They let me rant and rave. They calm me down. I am a true example of how much the RAIN staff has had to deal with. I will always be connected to the RAIN Program. I have been given an opportunity that I never dared dream possible. I have always found it easier to accept failure. Success was something I feared. Now I see I am going to graduate in a few weeks and I feel such a sense of accomplishment and pride. I'm still scared because I have to pass boards yet, but I know RAIN will be there with me every step of the way. Even if I stumble.

These stories are only a select few of many that could be told. The heart and soul of the RAIN Program belong to Deb and Barb.

University of North Dakota Indians into Psychology Doctoral Education (INPSYDE) Program

Status Update and Needs Projection: May 5, 2000
J.D.(Doug) McDonald, Ph.D., Director, UND INPSYDE Program

I. Brief Background and Needs.

American Indians are the most underserved minority group in America in terms of physical and mental health care. Despite suffering depression- and substance-related disorders and suicide at rates five to 10 times higher than the majority culture respectively, they graduate the fewest percentage of mental health professionals each year. The Indian Health Service (IHS) is historically understaffed and underfunded to meet the overwhelming mental health needs of American Indians. The ratio of Indian psychologists to the general Indian population remains lower than that for any other minority group, and certainly lower than that for the majority culture. The total number of American Indians with Ph.D.s in clinical psychology is still under 150 nation-wide. To date, only six American Indian psychologists are professors within American Psychological Association (APA) accredited clinical psychology training programs.

The UND INPSYDE Program

The Indians into Psychology Doctoral Education (INPSYDE) program was established (Senate Bill 2412) in 1992 to begin addressing these needs. The University of North Dakota was chosen as the optimal site for development of the first INPSYDE program by APA, but the program remained unfunded until last year. The UND INPSYDE program's objectives are to increase the number of doctoral-level Indian psychologists, as well as the development of cross-cultural competence in non-Indian students and faculty. Training toward a Ph.D. in Clinical Psychology typically lasts 5 - 6 years.

Funding Status

The UND INPSYDE Program received its first year of funding through IHS in July of 1996 at $200,000 per year.

Achievements to Date

The funding has been used to address all legislative mandates, including recruiting, retention, increased awareness of careers in psychology, and cross-cultural competence enhancement. Eight Indian graduate students are currently enrolled at UND, with six other placed in APA-accredited clinical programs elsewhere in the region. If this class of students **alone** matriculates as expected next year it would represent a 5% increase in the total number of American Indian clinical psychologists nation-wide. To date, the UND INPSYDE Program has produced two Ph.D. and 6 M.A level psychologists.

What is the next step?

While the INPSYDE program has been successful in its first four years, continued legislative support in the form of reauthorization of the Indian Health Care Reform Act and appropriations are vital to its survival. An increase in appropriations has been proposed for FY 2001.

American Indians are the most underserved minority group in America in terms of physical and mental health care. Despite suffering depression- and substance-related disorders and suicide at rates five to 10 times higher than the majority culture respectively, they graduate the fewest percentage of mental health professionals each year. The Indian Health Service (IHS) is historically understaffed and underfunded to meet the overwhelming mental health needs of American Indians. The ratio of Indian psychologists to the general Indian population remains lower than that for any other minority group, and certainly lower than that for the majority culture. The total number of American Indians with Ph.D.s in clinical psychology is still under 150 nation-wide. To date, only six American Indian psychologists are professors within American Psychological Association (APA) accredited clinical psychology training programs.

Mr. Chairman, the Quentin N. Burdick Indian Health Programs supports the work of IHS, particularly their commitment to providing quality programs to educate health care professionals. Thank you for the opportunity to share with you our concerns regarding the re-authorization of the Indian Health Care Improvement Act. Our success is attributed to the IHS support as well as the commitment of the colleges and their president's and faculty. We believe all three of these programs are essential avenues for the education of American Indians.

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June 14, 2000

Senator Ben Nighthorse Campbell, Chairman
United State Senate Committee on Indian Affairs
Washington, DC 20510-6450

Dear Senator Campbell:

In response to Question 1, Can our program be successfully duplicated on other campus? Yes, our program could be duplicated. To be successful, a program needs to have American Indian support staff, who have had the same lived experiences as the students. The students appreciate that someone else has been through and understands what it takes to commit to leaving home and pursuing their goals. It takes going beyond the eight to five work day. It means being available 24 hours a day. Helping students to be successful is very labor intensive. It means being involved in all aspects of their lives. Its putting your heart and soul into what you are doing with the students. You become mom, grandma, aunt to the student and their families, no matter what the age. It means accepting the students unconditionally. It means you never stop believing that the student can be successful even when they don't believe. Too often our students are more apt to accept their failures than their successes. Its hard for them to acknowledge and accept that its okay to be successful. Its making the student see a setback as just another opportunity. Its being a student advocate and making the students realize that they have options and they are responsible for their decisions. Its helping the students learn to balance their two worlds. Its creating a sense of belonging and a place where students feel they are welcome. Its having a place where there can be tears and laughter.

It takes a commitment from the parent institution for recruitment and retention. This commitment must be expressed in actions not just on paper. For example, it may mean having directors, who may not be American Indian, giving the staff the freedom to do their job and develop strategies that are appropriate for retention. It's having faculty who understand staff's role as a student advocate and are willing to be a part of the process. It's pleading with a faculty to be flexible, requesting they let a student redo a paper to raise a grade or having them understand that we can keep a student on track and in school even if they have had to go home twice in a month due to deaths in the family. It's having a financial aid officer dedicated to juggling the loans and bottom lines to get students through each semester. It's having a business officer willing to lift the hold on a student account so the student can get registered and get their financial aid. It's having the housing officer find emergency housing, or not evicting a student and willing to work on a payment plan. It's having a university president willing to give us tuition and fee waivers for our scholarship students because our budget cannot be stretched to cover these

UND is an equal opportunity/affirmative action institution

costs. It's having a college dean who will waive the program fees so we can stretch scholarship dollars. It's having private benefactors who will send us contributions to pay for students taking courses off campus. It's working with the instructors at tribal colleges to offer courses that will fit into our students' schedules or having them work independently with a student to retake a course. It's working with tribal higher education officer to fund beyond what they have budgeted a student. It's a grants management officer at headquarters letting you request dollars for coffee if it means retaining students. It means just because it hasn't been done before that you can't make it happen. Sometimes, it means looking beyond the rules and regulations to make a difference. It's realizing if our program was not in place, that we would not have the number of students completing their nursing degree.

A program could not be successful without all these components and more. We could not do our job if we did not have all these resources in place. It does take a village to raise a child. This is evidenced by the development of the RAIN Dreamcatcher/Medicine Wheel Model of Retention. It's the webbing that depicts the complexity of services required to retain American Indian students. Our program's workings and success goes beyond what is written in the goals, objectives and evaluation plans for the project.

In response to Question 2, the annual budget of our program? Our annual budget for the 2000-01 funding cycle is $159,701. As could be expected, we were very disheartened and disappointed in the continued reduction of our 2000-01 budget allocations. We were hopeful that the $21,500 that we had to cut from our operating budget the prior year would be reinstated. This did not happen. It is ironic that when RAIN was initially funded we had a higher level of funding and we were handling only a fourth of the students we are working with presently. For the 1999-00 academic year, we had 11 pre-nursing students, 24 baccalaureate nursing students, 4 associate degree nursing students and 8 graduate nursing students. We are still providing the same quality of services for more students with fewer operating dollars.

We have cut our recruitment travel tremendously for this coming year. Our travel has gone from $14,471 down to $3,377 in the last two year. We are quite certain that this action is going to impact our recruitment efforts. Yes, we know that RAIN is well known. This is because we have been visible out in Indian country recruiting. The fact is, people out in Indian country want to see our faces and not just hear our voices on the telephone (if they have a phone). They want us to know where they come from. They want us to meet their families. It will have taken the University and the College of Nursing 52 years to graduate our first bachelor prepared nurse from the Spirit Lake Nation of Ft. Totten, ND. This is the closest reservation to the University. The student will graduate in December 2000. It took the RAIN staff three years to recruit her before she actually came to the University three years ago. It was making sure that we stopped in and visited with the student every time a trip was made to the reservation. This could not have been done with just making phone calls or writing letters. Our operating budget would be in worse shape if it were not for the University agreeing to reduce indirect costs to 4%, instead of the usual eight percent.

Our scholarship dollars have always remained the same: $115,500. We have to wait until someone graduates before we can award new scholarships. We are definitely feeling the crunch with the RAIN scholarships. With the stipend and tuition cost increasing this year with no

increase in allocation we know we are only going to be able to fund seven continuation students this fall rather than the 10-12 we have funded in the past. It is very hard to recruit new students when there is no hope of them getting a scholarship from RAIN or the IHS 437 scholarship programs. It would be helpful if at some point we could freeze the stipend amount to stretch our scholarship dollars. We already request the University charge only in-state tuition on our out-of state students. It is also important that you realize the RAIN Program is further supported through private donations and a variety of university and college contributions, however, these in no way compensate for the ongoing budget reductions from IHS.

In response to Question 3, why do the vast majority of our graduates stay in Indian country and serve tribal people. We believe it is because we recruit the students from the reservations. They have lived experiences with reservation life. They have a strong commitment and connection to real people and places. They see the turn over of physicians and see that it is the nurses making the long term difference in the health of their people. Their sense of belonging to their communities is stronger because they return to the reservation sooner to work and take care of people than do the physicians. A nursing student is away from home for three or four years compared to a medical student who is away from home for a minimum of 12 years. Nursing students have more opportunities to work at home in the summer time during their nursing program on the IHS Externship program, so their connection continues with home throughout their nursing program. Medical students do not have as many opportunities to return and work in their communities while they are going to school and receiving their training.

In response to Question 4, what else can be done to ensure that the number of American Indian and Alaska Native health professionals continues to increase? It is so important to continue the financial support of IHS Scholarship Program, and the programs like RAIN, INMED and INPSYDE. The scholarship support is so crucial to the success of our students. We have seen a tremendous difference in student's academic performance once they are awarded the IHS and RAIN scholarships. They know have some financial security and do not have to worry about how they are going to put food on the table for their children. They do not have to worry about having to work and lose study time. We have had students turn down admission to the College of Nursing because they cannot afford to attend school without scholarship support.

Another way to increase American Indian health professionals is to provide financial support for LPNs, AD-RNs, BSNs, to upgrade their education. We have been told by Nursing at IHS headquarters that within 5-10 years, IHS is going to be experiencing a nursing shortage crisis. There are **3,181** nurses in the IHS—Overall, **877** are over the age 50 years old—**1,180** are between the age of 40-49 years old—only **1/3** (less than 1000) are American Indian.

In response to Question 5, do we attribute the success of the INMED Program to the fact that this programs follows students from high school through undergraduate and medical school? Yes, and actually they start following students from the junior high school level. There is no greater sense of personal pride and accomplishment than to see some of the physicians and nurses working out there in Indian country and to know that you knew them when they were in junior high and high school and that you had a small part in what they are doing today.

These summer enrichment programs are so crucial to the goal of increasing the number of American Indian and Alaska Native health professionals. These programs offer the academic enhancement needed for students to be successful. They offer an early exposure to campus life and support services available. These young people are able to see Indian college students at different levels in their pre-professional and professional programs. These programs are the future of Indian health care delivery. We would like to provide such a summer program for pre-nursing students, however, we have not been able to secure funding. The INPSYDE program has a summer component- one that faculty and staff believe is crucial to the student's academic success. The cost of providing these types of programs is great for many reasons - recruitment, student support, travel, planning, etc.

I am honored to be able to respond to your follow-up questions. I thank you for giving me the opportunity to speak in support of the reauthorization of the Indian Health Care Improvement Act.

Respectfully,

Barbara Dahlen, MS, RN, FNP
Assistant Coordinator, RAIN Program
Clinical Assistant Professor
College of Nursing
University of North Dakota
Box 9025
Grand Forks, ND 58202

TESTIMONY OF GERALD DANFORTH TO THE SENATE COMMITTEE ON INDIAN AFFAIRS

Good morning Chairman Campbell, Ranking Member Inouye, and members of the Committee. My name is Gerald Danforth, and I am the Chairman of the Oneida Tribe of Indians of Wisconsin, a federally recognized sovereign tribal government representing approximately 14,000 members, located just west of Green Bay, Wisconsin. I want to thank you for the opportunity to appear before you today.

Mr. Chairman, as you know, there is a tremendous shortfall in resources for Native American health care. This is why it is necessary for the Indian Health Care Improvement Act be reauthorized. I would first like to discuss Oneida's participation as one of the delegates to the National 437 Steering Committee (Public Law 94-437, Indian Health Care Improvement Act). As a participant on the steering committee, the Oneida Tribe took great interest in contributing to the redrafting of Title III, Health Facilities, and Title IV, Health Care Financing. I would also like to take the opportunity to address the current shortfall in funding for new health facilities, its impact upon the health of Oneida members, and a proposed innovative solution to that problem.

NATIONAL STEERING COMMITTEE: Reauthorization of the Indian Health Care Improvement Act

In June of 1999, the Indian Health Service convened a National Steering Committee made up of the IHS, Indian governments, and urban Indian organizations. The initial plan for the National Steering Committee was to develop broad concepts and general ideals for the distribution of federal funds for Indian health. After the initial meeting, however, the National Steering Committee decided to tackle a comprehensive redraft of the Indian Health Care Improvement Act based on the consensus recommendations developed at four regional consultation meetings. The members of the National Steering Committee and its staff put in thousands of hours into the draft of the Indian Health Care Improvement Act. The final proposed bill was presented in October of 1999, to the Director of the Indian Health Services and to each authorizing committee in the House and Senate.

The National Steering Committee allowed the Indian Nations of the United States, including the Oneida Tribe, to have a powerful voice in the amendment and renewal of the preeminent Indian health care law. The Oneida Tribe devoted the time of its government officials, health care administrators, and attorneys to the National Steering Committee, and we are satisfied with the resulting draft. The Oneida Tribe fully supported and continues to support the proposed Indian Health Care Improvement Act reauthorization amendments as the most feasible solution for the advancement of Indian health.

JOINT-VENTURE PROGRAM: Solution to Shortfall in Health Facilities Funding:

According to the five year IHS Health Facilities Planned Construction Budget, there is a $938 million need for new construction of health facilities in Indian Country. Considering current funding levels, even those tribes who manage to secure a spot on the very exclusive IHS Health Facilities Construction Priority List today could have to wait 60 years for their facility to be built. As a consequence, the existing health facilities are outdated (average age - 32), difficult to maintain, inadequate, and in desperate need of replacement.

Inadequate facilities and lack of access to medical care contribute to the high rates of Native American deaths due to treatable health problems. According to the IHS, the death rates in the American Indian and Alaska Native population, as compared to the general population, are seven times greater for alcoholism, six times greater for tuberculosis, three and a half times greater for diabetes, and three times greater for unintentional injuries.

These frightening health statistics are some of the main reasons that the Oneida Tribe participated in the National Steering Committee's Health Facilities workgroup. We felt that the Oneida Tribe needed to become a leader in researching and creating innovative means to alleviate these health facilities concerns. The Oneida Tribe sponsored a meeting on the Oneida Reservation and invited numerous tribes to discuss alternative funding mechanisms for health facilities. These discussions inspired Oneida to become an advocate and leader for tribes interested in pursuing funding through

the Joint Venture Health Facilities Program.

In Oneida, our health department struggles to meet the demands of an increasing population in an aging building that is woefully undersized. In our two county service area alone, the existing Oneida Community Health Center has experienced an annual patient growth rate of 9.2% between 1990 and 1997. We now have three trailers sitting outside our facility, and we may have to add one more. Oneida patients and doctors alike must wait for examination rooms.

Patients must wait months for everything from medical, dental and optical services to emotional counseling services. Patients cannot get an appointment with a doctor at the Oneida Community Health Center for at least one month. The average wait for adult dental care is three months, and there is a three and a half month wait for basic teeth cleaning. Furthermore there is a two-month waiting list for optical appointments. The resulting inability to serve our members is devastating.

Our substandard service facility also creates an endless battle to hire and retain doctors and medical staff. We have had two physician positions vacant for the last four straight years, making it difficult to meet the needs of our population which has high incidences of diabetes, cardiovascular diseases, and respiratory problems. All of these problems require a higher level of care than mid-level practitioners are capable of providing. The alternative of purchasing the services of doctors in the Green Bay area clinics is prohibitively expensive.

Because of the lack of federal funds, however, the Oneida Tribe will have to wait at least two generations for the federal government to construct a new facility. We cannot afford to sit idly by while our people suffer needlessly.

Our proposed solution is joint venture. We will finance the construction of an adequate facility if the IHS will equip and staff the facility. The Oneida Tribe, along with other members of the Tribal Nations Joint Venture Coalition, are working to develop and construct facilities with funds they would generate by bonding or through other governmentally-secured promissory notes. If IHS were

to assume the costs associated with equipping and staffing these facilities through cooperative agreements with the Tribes it would be possible to construct appropriately-sized and equipped facilities to provide adequate health services.

Such IHS equipping staffing is already authorized in law as the Joint Venture Demonstration Program. The proposed amendments shorten the no-cost lease to the IHS provisions in the Joint Venture. This provision makes it possible for more tribes to show financial viability and participate in the program. With adequate funding for the Joint Venture program, three or four tribes annually could complete the construction of their facilities, putting them up to sixty years ahead of schedule.

In Oneida, the Impact would be tremendous. With a new and expanded health center, the Oneida Tribe could increase the number of diabetes prevention and treatment visits by over 140% in the first year alone. Other categories of medical need could be similarly boosted. Our general medical clinic is currently providing only 68% of the visits needed. The number of visits would increase by nearly 10,000 visits in the first year alone if an adequate new facility was constructed. Our dental, optical, and women's health departments would also be able to double their number of visits annually, thereby reducing the current long lists of waiting patients, and getting preventive care to people before their conditions become serious and more expensive to treat.

Mr. Chairman, the Oneida Tribe of Indians of Wisconsin, the numerous members of the Joint Venture Coalition for Health Facilities, and other tribes look forward to working with this committee to develop viable alternatives to the current dramatic health needs in Indian Country. Meaningful cooperative agreements such as the Joint Venture program outlined in the proposed Indian Health Care Improvement Act provide an appropriate and focused approach that can move us beyond the desperate situation that currently exists. The Oneida Tribe strongly encourages you to support funding for the Joint Venture Program proposal, and we ask that you encourage your colleagues on the Appropriations Committee to do the same.

Oneida Tribe of Indians of Wisconsin

BUSINESS COMMITTEE

Oneidas bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the colonists had consistently refused to aid them.

00 JUN 20 PM 4:43

UGWA DEMOLUM YATEHE
Because of the help of this Oneida Chief in cementing a friendship between the six nations and the colony of Pennsylvania, a new nation, the United States was made possible.

P.O. Box 365 • Oneida, WI 54155
Telephone: 920-869-4364 • Fax: 920-869-4040

June 15, 2000

The Honorable Ben Nighthorse Campbell
United States Senate Committee on Indian Affairs
838 Hart Office Building
Washington, DC 20510

RE: Responses to Joint Venture Questions.

Dear Senator Campbell:

Thank you for your inquiries on the Oneida position on joint venture. We look forward to working with you and the Senate Committee on Indian Affairs to enact the joint venture language of the Indian Health Care Improvement Act. Hopefully the following will provide adequate answers to your questions:

Question: *In your testimony you mention that the IHS construction priority list is exclusive. Why or how are tribes excluded?*

> The IHS Health Facilities Construction Priority List is exclusive in that only those locations with a "federal presence" or locations have an existing federal facility meet the criteria for replacement. It is extremely rare that any new facilities qualify for placement on the Priority List. There is a 35 year "backlog" for those locations already on the Priority List. Therefore is no opportunity for additional facilities to be constructed or reconstructed. The need for new facilities far exceeds the funding.

Question: *How many tribes are in the Tribal Nations Joint Venture Coalition? Are all these tribes willing to use their own funds to building their own facilities?*

> When the Tribal Nations Joint Venture Coalition was formed, fourteen tribes were present at the meeting held in Oneida, Wisconsin. Eleven of those tribes sent in tribal resolutions supporting the efforts of the group, and the other three did not feel they were ready to make the monetary commitment at that time. The list has now grown to twenty-seven (27) supporting tribes. Some of the twenty-seven could not wait for authorizing legislation, and

they have moved ahead with funding their own facilities. Their health care needs were so dire that they could not afford to wait for the federal government to meet its trust obligations.

Question: *If the Joint Venture Program were to be funded, would tribes be willing to assume partial costs for staffing for the facility, all of which would eventually be assumed by the IHS? For example: would the tribe build a facility then pay an increasingly smaller percentage of the staff costs over a period of five years - 80% the first year, 60% the second year, etc., until they pay nothing for the staff or equipment and the IHS assumes all the costs?*

The Joint Venture Program was developed for the purpose of sharing between an individual tribe and the federal government the costs of the construction, staffing, operating, equipping, and maintaining health facilities. If tribes were to pay for the design and construction (approximately ten to fifteen million dollars) of their respective facilities and then pay the initial costs of staffing, operations, and equipment; there would be no "joint venture." This proposal would, in effect, pay for the trust obligation of the federal government with tribal dollars. I do not believe this would be a viable option.

I hope my answers can be of some help to you. Please feel free to contact me if you have any questions on my comments.

Sincerely,

Gerald L. Danforth, Chairman
Oneida Tribe of Indians of Wisconsin

Testimony for Senate Committee on Indian Affairs

Presented by Douglas Eby MD MPH FAAFP
SCF VP Medical Services

Representing: Southcentral Foundation – Alaska Native non-profit health corporate arm of Cook Inlet Region Incorporated located in Anchorage, Alaska.

Outline

I. Introduction
II. Advantages of Local, Native Customer-ownership
III. SCF Steps to Transform Health Services
IV. SCF Plans for Further Improvement and Expansion
V. Role of the Indian Healthcare Improvement Act

May 10, 2000

It is an honor to be able to address this committee on behalf of the Southcentral Foundation Board of Directors, the President/CEO – Ms. Katherine Gottlieb, the corporate vice presidents and the staff.

I come to you as a corporate vice president and a physician administrator privileged to work for a Native corporation, Southcentral Foundation (SCF), in the service of the Alaska Native peoples of Anchorage, Alaska. SCF has a long history of developing and providing innovative, community based health programs and we are proud to share with you some of what we have been able to do.

The past several years have been particularly challenging and exciting as Alaska Native leadership have completed the process of transferring all remaining Indian Health Service programs in Alaska to Native ownership and management. This includes the transfer of the largest Indian Health Service facility and medical system in the United States – the Alaska Native Medical Center. We have then proceeded to transform the system into one that is becoming one of the finest anywhere in the entire country.

II. Advantages of Local, Native Customer-Ownership

There are many reasons why the transfer of ownership and management of programs previously under the I.H.S. has been a good thing for health systems. Some of them include:

Customer ownership – health systems are best when in the hands of those for whom they provide services. Healthcare is a service industry. Service industries are best when closely attuned to the customer and there is no better way to assure this than by putting the system in the hands of the customer.

Native ownership – the services SCF offers are for Alaska Native clients. Services offered by a Native-owned system are naturally going to be more Native appropriate.

Private corporate ownership – the change from being Federally owned to being a private healthcare corporation has opened a lot of doors. SCF has been able to add millions of dollars to provide expanded services through grants and contracts previously unavailable to the Federally owned system.

Local ownership – being a self-contained, local corporation provides the opportunity to be locally focused and more rapidly responsive than was possible with a large government system centrally controlled from 5,000 miles away. Our ability to understand local dynamics and to partner with other local groups has expanded our ability to provide services.

The improvements with 'Compacting' – the flexibility afforded SCF by the compacting relationship where SCF has considerable freedom in controlling and reshaping systems to be more appropriate to the local situation has allowed considerable improvements in service delivery.

In the following pages we describe what we have done in developing new programs and transforming those we have taken over from the I.H.S. The most recent example is what we have done in the past two years to completely transform the services we took over from the Indian Health Service at the Alaska Native Medical Center (ANMC) in the spring of 1998.

We spend considerable time learning about cutting edge ideas transforming healthcare nationally. We then adopt the best practices we find nationally, put them together in new ways, and adapt them to our system. By adopting and adapting the best healthcare system practices nationally and combining that with the wisdom and the strength of the Native community we have created the best of all possible worlds and are convinced *we are creating something very special and very impressive.*

One example of what we have done is that in the past year we have helped nearly 30 thousand clients choose their own primary care provider for them and their family, made it possible to see that provider consistently over time, and have *access to that provider for whatever they want when they want it.* It is now possible for these clients to call today and be seen by their provider today for whatever they need.

This system is also a *relationship-based system of care* where each visit builds on the previous one. Patients don't have to tell their whole story from the start over and over. It allows the primary care team and the client to get to underlying issues that really determine illness and health. These issues include such things as depression, substance use, violence, relationship difficulties, obesity, smoking, etc, etc. The opportunity to not just deal with the immediate crisis, but get to the real determinants of health and wellness finally exists.

Systems like this allow the provider, case manager, and client to get more real work accomplished every visit. Over time the patients' ability to do more for themselves and make their own healthcare decisions goes up. Patient satisfaction and provider satisfaction go up. Healthcare outcomes improve, ER visits go down, and hospital admissions decrease. Over time outpatient visits also go down. In other words efficiency improves while effectiveness improves and satisfaction of everyone goes up. It is possible to do. We are doing it.

We are also rapidly and effectively putting the health system *into Native hands* at all levels while developing highly capable Native leaders and increasing the availability of clinical staff by giving them better non-clinical support. In the past the I.H.S. system used doctors and nurses as the only managers in departments. We now have professional managers who are Alaska Native that we train in budget and personnel management in addition to all additional management skills. We allow the clinicians to return to predominantly clinical work while providing overall direction and we have added considerable business and personnel expertise to the clinical expertise already existing. *It is a change that has improved everything about how the system is managed while putting the system into Native hands and building highly capable Native leadership for the future.*

We have also taken all of our programs – developed and inherited – and made them into a planned, intentional system of care. Way too often healthcare consists of a bunch of loosely connected program 'islands' that create a lot of duplication of effort, poor hand-offs, and inefficient and ineffective care. We have outlawed 'islands', have instituted population based thinking and planning, and *have created a system of care that is centered around how it works best for the client and how the client wants it.*

Additionally we have taken the unique strengths of the Traditional Native way of doing things and added that to the predominantly allopathic medical system we inherited and developed. This includes the incorporation of Native ways and thoughts into our mainstream health systems. It includes the development of particularly Native programming that targets youth and adults in difficulties who need to rediscover strong roots and identity to move toward health. It has meant redesigning programs around the Native family and community. It has also meant investing heavily in helping all of our staff understand Native history, Native cultures, Native priorities, and Native ways.

We are convinced that publicly funded, well-managed healthcare systems in the hands of the customers are the most effective model for healthcare delivery provided there is effective and accountable management. Much of what is known as 'managed care' in the United States has resulted in conflicted incentives where the advantages of this approach are lost in the competing incentives of poorly designed systems. We believe we have demonstrated that when you align the incentives correctly and create the right combination of incentives, you can create truly impressive and effective healthcare delivery that produces amazing outcomes while improving efficiency and effectiveness.

The following pages list in brief, bullet form what we have done to transform our system. This is followed by a brief description of what else we intend to do if funding can be expanded.

III. SCF's Steps to Transforming a System of Healthcare:

At SCF we have undertaken a complete system transformation of what we inherited from the I.H.S. and incorporated it into what we developed ourselves. Changes have occurred in philosophy, structure, and direct services offered our customer-owners. The list below contains many of the elements that went into this system transformation and each is further defined in sections that follow.

Mission driven organization
Senior Management alignment and support

Unwavering customer focus
Customer-owner solidification
Population based approach to system design
Team Management
Intentional, planned Native management development and implementation
Business oriented management development
Access to care
Relationship based Primary Care Provider system
Case Management
Integration of Departments – System of Care
HR processes redesign
Aligned incentives throughout the system
Central Budgeting and Planning
Intentional Planned processes
Alignment of Processes
Improvements in Clinical Quality
Facilities
Effective Budgeting for the long term
Long term thinking and planning
Expanding rural ASU system of care
Continuum of Care
Development of partnerships and other sources of funding

1. Mission driven organization

Mission, vision and key points everywhere – on walls, pens, shirts, mouse pads.
Job Descriptions and evaluations based on these statements and values. For example, everyone in the organization – everyone – is evaluated on Team Contribution, Communication, and Professional Responsibility.
The entire management structure and decision making process has been revamped.

2. Senior Management alignment and support

The SCF Board, the CEO evaluation, the Board driven priorities, the corporate plans, etc. are all driven by the mission and key points. The Primary Care Plan being implemented was a product of customer, staff, management and Board input. It was approved and supported at all levels before implementation.
The Board and President/CEO themselves continually and strongly support the Mission and Key Points.
Communication, planning, and updates flow up and down the system continually in order to keep everyone aligned.

3. Unwavering customer focus

Systems were changed dramatically to bring services to the patient rather than have the patient go to lots of different locations.
Continual feedback and accountability regarding patient/customer experience.
Corporate wide expectation that things will go right.
Unwavering passion from CEO regarding a high performing system and intolerance of second best.
Active customer service team with many activities. Is a standing agenda item at every managers meeting.
Current development of the Patient Resource Center.
Development of Patient Advocate system in the hospital.
Development of greeters.

Development underway for short-term child support while adult receives care.

4. Customer-owner solidification

Transition from Federal system to Native ownership and oversight complete

Continual reminder to management and staff that the SCF Board ultimately controls the shape and priorities of the corporation.

Placement of Native managers in every department in Medical Services is completed.

5. Population based approach to system design

Departments in the Federal system of the past were basically employee centered. Work was defined as seeing those patients that managed to figure out the system well enough to get onto provider's schedules. There was created a constant tension between patient demand and employees 'protecting' themselves.

All departments now told they must think about the entire population they have expertise to offer and how best to deliver services to that entire population.

Departments are encouraged to think system wide and find ways to support others doing some of the work and reserving to themselves those things that only they can do.

Examples:

Mental Health – Now thinks of the entire Anchorage population, and to some extent the ASU and the entire state. They are working with PCP's (Primary Care Providers) and case managers in other departments to build their capacity to handle basic mental health issues. They have assessed how the customer uses the system and are in the process of redesigning their processes to match customer use.

Women's Health – They are working to create standardized care for women wherever they are seen – women's health, family medicine, urgent care center. They are focusing on standardizing and improving pregnancy care. They are working to develop ways to be more efficient and effective in their specialized areas of gynecology and gynecologic oncology.

Pediatrics – Similar to Women's Heath. They are working at standardizing and building capacity for children no matter where they are seen. They are developing a center of excellence around fetal alcohol affected children. They are building relationship based, continuity oriented, same day access capable primary care.

Family Medicine – Have created and implemented a relationship based, continuity oriented, case management empowered, same day access capable system for all adults in the ASU and all children who choose to use this system.

6. Team Management

Every department of significant size has a management team

The larger clinical departments have an outpatient clinic management team, an inpatient management team, and an overall physician medical director.

Decisions are by consensus and are to have included input from all levels of the department and are to have included consideration of the patient/customer.

Teams include clinicians and non-clinician professional managers.

Our nursing leadership have been instrumental in driving the creation of a shared governance system of nursing input across the campus.

The nursing shared governance process has created nursing councils that help standardize processes and align incentives.

The new Medical Staff Bylaws at ANMC create the structure and system for more activist involvement by the medical staff in quality of care.

7. Intentional, planned Native management development and

implementation

A system of advancement is in place. One can advance from Clerk I to Clerk II to Support Coordinator to Clinic Coordinator to Health Systems Administrator (levels I, II, and III) to Vice President.

Creation of Clinic Coordinators. These are office managers for most of the programs. These are, by definition, Alaska Native managers. They are mostly young, college graduate managers with little hands-on experience. Through an intentional, mentored process they develop into very capable, highly responsible office managers. These are now the day to day managers of the departments.

SCF has a well-developed program of support for those pursuing education and degrees. Time off of work is provided, support during pursuit of advanced degrees, and large amounts of non-degreed skill development is supported.

8. Business oriented management development

In the past managers of departments were doctors and nurses plucked from the current department. With the addition of full time clinic coordinators there are business-oriented managers in every clinical location.

Budgets are now developed with considerable department input. Budgets are then given to departments to manage.

We are starting to see department management see their operations as a budget rather than a collection of FTE's. There is still a long way to go.

We have worked to bring a higher priority to the revenue collections system.

9. Access to care

Our patients want access to services – above all else.

Our patients want access to their PCP. They don't want to have to tell their story over an over to new providers every time.

At SCF we now have PCP's whose job it is to meet the needs of their panel of patients. Over 25,000 persons in the ASU have chosen a PCP (or had one assigned in the case of rural villages).

The rule is 'do all of today's work today'. The only reason for a patient to not be seen today (for anything) is if the patient requests otherwise or it is a scheduled follow-up appointment. Same day access for anything the patient wants is the rule.

At present we are matching patients and PCP's in actual visits around 55-70% of the time (used to be 20-30%, national best practice is 65-75%) and every PCP's schedule is half-open at the beginning of the day.

10. Relationship based Primary Care Provider system

Sustainable, significant lifestyle change and effective patient education only occur in longitudinal relationship based systems. We have created such a system.

Every patient now sees their chosen PCP when they want to see them unless they are out of town. Every visit builds on the previous visit. This system allows the client and provider to get past the superficial issues to the underlying true determinants of illness and health.

The team of PCP, Case manager, floor nurse, patient and family is a critical component.

Patient and family Self-Care is a cornerstone of this system.

11. Case Management

There is now a strong body of evidence to show that good, pro-active case management is essential to effective care of chronically ill and medically fragile patients.

There is strong evidence that hospitalizations go down, overall health care expenditures go down, quality of life goes up, patient satisfaction goes up, and provider satisfaction goes up in a case management oriented system.

SCF has integrated immunization money, diabetes money, and research grant money into the case management system. What has resulted is a one-to-one ratio of physicians and case managers.

Case managers coordinate village care, follow-up care for patients who are seen, and proactive case management for those for whom it is appropriate.

12. Integration of Departments – System of Care

The SCF Board and CEO have mandated an integrated system of care

SCF management has adopted a 'no more islands' mantra

The Federal system at ANMC ran the place a loose collection of independent, hardly accountable islands pretty much left to their own devices. SCF has outlawed such a system.

All departments and systems are to orient themselves to support the PCP/Case manager/patient/family partnership.

All specialty departments are to spend part of their time and energy building and expanding the PCP team capability.

All specialty departments are to creatively explore effective ways to create relationship with the PCP team.

Departments have entered into 'Service Agreements'. Service agreements define what each department will do and how they will relate to the other departments. For example Pediatrics and the Urgent Care Center have a service agreement that defines the role of each with children, how they will pass patients between themselves, how they will standardize and coordinate care, etc. These are now in place for the most part.

Nursing has developed its shared governance structures and processes. The nursing councils and associated activities are assuring integration and standardization of nursing activities across the campus.

Community education redesign to pull together 'islands' of previous I.H.S. programs.

13. HR processes redesign

Over the past several years every job description and every performance evaluation was rewritten to be in alignment with SCF mission and key points.

SCF is now well along the road of revamping the entire corporate system of personnel management. This will include further standardization of job categories and pay. It will include the implementation of an incentive pay system. It will include a redesigned performance evaluation system that is more objective and will require ongoing, continual management feedback to staff.

Aligned incentives throughout the system

The SCF system of same day access to the same PCP will work best for staff if they:

- Help patients and family do more self care. So patient education and involvement is directly and tangibly rewarded.
- Work as a team. Any physician who insists on doing everything themselves is going to suffer terribly in this system.
- Phone management is rewarded. Saves the patient and the physician time.
- Increased PCP knowledge and capability is rewarded. Specialists get direct benefit from working at this.
- Every visit builds on the previous one.
- Max-packing is rewarded – doing everything you can in this visit (prevents future visits decreasing the number of times the patient has to come in and the number of

appointments in any given day for providers).

Effective, pro-active case management is rewarded. Patients who are better controlled medically are healthier and come in less. Quality of life improves for patients and staff.

Prevention is rewarded. Illnesses prevented are patients needing less medical care.

Underlying root cause issues are addressed. Since every visit builds on previous ones trust is developed and there is time to address issues of depression, substance abuse, violence, obesity, lack of exercise, etc. In the short run utilization may increase, but over time it should decrease and health should be more likely to increase.

The system encourages and rewards the above actions directly in more manageable and satisfying professional lives. The feeling of treading water or constantly fighting a non-ending onslaught of patient demand goes away. The feeling of real progress is achievable.

Specialty departments are rewarded by supporting the PCP system of care. Their work becomes more manageable and rewarding.

The nursing self-governance process builds on and rewards participatory processes throughout the system. It also standardizes processes across the campus.

15. Central Budgeting and Planning

SCF requires every department to sell their requests for increases in language that describes how it would help the entire system of care.

There is effort to have all departments provide comment on the entire list of proposals.

All revenues go into a central fund and enhancements are mission driven, not revenue generation driven.

Planning efforts are around a system of care and defined corporate priorities drawn from the mission and key points.

All division and department goals are aligned with Board approved corporate goals.

16. Intentional Planned processes

The systems we inherited from I.H.S. were the way they were mostly because of personal passions, effective lobbying, and responses to crisis. In other words, mostly an accident of history.

We have mandated a system of care – intentional, planned systems developed in response to customer needs and wants. Things will be the way they are because we intended them to be that way.

We prioritize knowing what our customers want and looking far and wide for proven systems that can deliver on those priorities.

What we are creating is our own customized integration of best ideas and best practices from all over healthcare. We have taken the systems that address our customers needs and wants and modified them to meet our local needs and realities.

All lobbying by departments for more funding must be justified by how it supports the system and furthers the mission and goals of our whole system.

Budgeting, allocation of time and energy, and attention of senior leadership must be driven by intentional, planned priorities and plans.

17. Alignment of Processes

No individual or department can create their own reality

See the list of ways the system aligns priorities for PCP's and rewards them for this alignment.

See list of ways departments are being integrated and creating intentional, written Service Agreements.

18. Improvements in Clinical Quality

Creating an intentional system of care allows the possibility of coordinated approach to many areas. One area of national attention at present is increasing medical quality by simplifying and standardizing processes. Through this effort decreased medical errors should occur and patient safety should increase. At the same time patients will be getting more consistent input and best practices should be spread more quickly.

1 The nursing councils have gone a long ways towards operationalizing this in their areas of influence.
2 SCF has a physician working full time (temporarily) on clinical protocol development in order to disseminate best practices and standardize practice to extent it makes sense to do so.
3 We are putting in place an intentional, planned approach to coordinating improvement activities of all sorts.

19. Facilities

SCF proactively made the ANMC campus work by creating the PCC (Primary Care Center) three years ago.

SCF planned from 4 years ago the expansion of the PCC.

SCF is rapidly designing and building the PCC to handle at least the next 10 years of volume

Considerable work on evaluating and developing off campus capacity for many different programs.

Within the past 12 months and the next 12 months SCF will additionally be providing new or improved facilities for:

Dena-A-Coy (nationally recognized residential treatment program for substance abusing pregnant women)
Early Headstart program
the Pathway Home (a whole system of various levels of care for troubled youth – still in development and recruitment of funding)
Our Mountain View satellite clinic,
Nutaqsiivik (nationally recognized innovative system of intensive case management for socially highest risk families with newborns)
Pacific Home Health - our other home based services including Personal Care
our health promotion and research program,
Quyana Clubhouse (for the chronically mentally ill)and
Our large collection of Behavioral Health programs.

20. Effective Budgeting for the long term

Creating sinking funds for equipment and capital costs should allow the system to remain equipped and housed without crisis intervention long term.

Creating and solidifying components of the system in sustainable ways.

21. Long term thinking and planning

Planning facilities for the long term future
Creating financial tools that allow sustainability
Strong attention to funding sources and sustainable funding

Creation of the Primary Care System was in a forward thinking mode that is creating a system that should be sustainable for the long-term – even if budgets flatten and population increases. Is a much, much more effective and efficient system of care and allows us the possibility of providing care to more individuals over time within available resources. Lots of rework and redundancy are removed.

This new primary care system builds clinically for the long-term as well.

Every primary care visit builds on the previous. Every effort is compounded in positive ways to not just treat acute illness, but to better manage chronic illness, prevent illness, and create the environment for promoting wellness. Actually getting to the underlying root causes of illness (lifestyle decisions, depression, violence, etc) is possible. The rewards of good illness prevention and improved wellness are paid back to the system over decades and lifetimes. In a system such as ours where clients, families and communities use the same system for generations, the system actually gets these paybacks structurally and financially. ***It structurally and financially encourages illness prevention and wellness promotion. All health programs and structures should be like this if illness prevention and health promotion are really to be supported by the healthcare system and healthcare cost are to be controlled..***

22. Creation of a rural ASU system of care

Support of the $5.5m expansion of rural ASU programs
Programmatic and technical support to village systems.
Definition of current system and customer satisfaction with system through the Craciun survey.
Development of an effective, structured method by which SCF and the healthcare system can hear and support the voice of village leadership as the independent voice of the rural Anchorage Service Unit.
Much attention has paid to improving the relationship of SCF to rural ASU groups. Tremendous headway has been made.

23. Continuum of Care

Examples of SCF efforts:
- Purchase of Home Health Agency
- Developed Personal Care Attendant program
- Development underway for Hospice and Respite services.
- Development of Traditional Healing program
- Addition of (limited) Chiropractor services
- (Limited) Acupuncture and Biofeedback services
- Expansion of Community Education efforts
- ***Development of adolescent treatment system – Pathway Home***
- ***Development of adolescent work experiences – summer and winter intern programs (impressive SCF initiative to bridge youth into the work environment and the consideration of choosing work in the healthcare environment – with particular emphasis on at-risk youth).***

24. Development of financial stability, partnerships, and other sources of funding

Continual attention to Federal congressional relationships and continual documentation of needs provided to them to support funding requests.
Astute attention to I.H.S. systems of expanding and solidifying funding.
Attention to competing for all I.H.S. funding sources.
Partnering with city, state, and other partners to extend our funding. Examples:
- Mountain View Clinic partnership with ANHC (community health center)
- Community Mental Health Center grant
- Valley contracts
- Dena-A-Coy partnerships
- Pathway home alliances

Pursuing research and clinical improvement grants:
- CDC Breast and Cervical Cancer Prevention Initiative
- Cardiovascular Risk Reduction research
- Komen Foundation funding
- Run For Women funding
- NIH exploratory grants
- Many, many other corporate based grants.

IV. Remaining needs and SCF plans to meet them

Adolescent programming

Teens are at the top of many disturbing health trends. These include violence of many sorts, substance abuse, suicide, depression, alcohol abuse, inhalant abuse, etc, etc. Alaska Native youth top all lists for many reasons. Some of them have to do with the transitions from village to urban life, from the lack of clear future possibilities, from a loss of identity as a Native youth, and much more.

SCF Plans:

The Pathway Home program – this is a comprehensive system of programs from residential treatment for high risk and medium risk youth and outpatient treatment for lower risk youth. The program will include therapy, job training, completion of high school education, and employment skills.

Intern Trainee program – SCF has already developed this program and has had several hundred youth in it. This program exposes Native youth to the healthcare environment and the world of work in a controlled, intentional way. It helps bridge from school to work and assists youth in completing high school and moving on to further education and training.

Home Health Care

Indian Health Service has not provided home based services. We have quite a number of persons for whom receiving care in their home would be very advantageous. Getting the right care to those confined to their homes provides better outcomes and better patient satisfaction while decreasing hospitalizations and overall cost. The VA did a very large project where they provided intensive home based services and lowered overall health system costs to one-sixth of the cost! The ANMC hospital facility is full most of the time and the system has limited funding. It would appear that our system would benefit greatly from expanded home based care.

SCF Plans:

We have acquired a home health agency. We are seeking funding to expand the system to the point it can be an effective addition to the healthcare system.

Hospice

Helping patients spend their last months with family in the setting and the way they choose is a strong Native cultural priority. I.H.S. provided for no hospice care. It is unforgivable the Native patients and families are not provided this important option. There is also impressive research data to show that effectively run Hospice programs can decrease costs in the last year of life to one fourth of what is the usual amount spent!

SCF Plans:

SCF is exploring what is required to provide certified, capable hospice care. We are actively pursuing all funding sources we can to try to

provide this important service.

Mental Health Services

As our greatly improved primary care services work at getting to the underlying issues of illness and wellness, we uncover a great deal of mental health issues. It is imperative that we be able to provide the extent of mental health support to our primary care system.

SCF Plans:

Expand mental health services as we are able.

5. Health Information Management

Our system is structured around putting health information into the hands of our clients and helping them make decisions about their health issues.

SCF Plans:

Create a Patient Resource Center. We are working with consultants to create systems of health information for clients and staff that put the appropriate information in their hands when and where they need it.

Create a comprehensive system of information management for our clients. We are designing a system where the information desk staff, the receptionist staff, the health information staff, and other support staff are part of an intentionally designed system of information management to help our clients find what they need in services and information.

Integrate health information management, our community education system, our nutritionists, our patient advocates, and our social workers into a coordinated system of support that works efficiently and effectively for our clients.

Head Start Expansion

Getting young children off on the right foot early in life is critical. As Native families move to the urban setting, getting early educational skills is a challenge for many. We run a limited Head Start program that could be expanded to many, many times its current size in order to meet the need.

SCF Plans:

Open Early Head Start program – just opened by SCF, but limited in size.

Expand Head Start – a high priority.

Complimentary and Alternative Health Services

Just as in the rest of the country, our clients have considerable interest in health services that aren't usually part of the allopathic medical system.

SCF Plans:

We are stepping into this carefully and cautiously. We are providing very limited acupuncture and chiropractor services. We would like to expand both of these services and add massage therapy. We have no plans to expand beyond that at present.

V. Role of Indian Healthcare Improvement Act

We at SCF took an active role in the rewriting of the Reauthorization Act. We worked with other Native leadership from Alaska and across the nation to assure that this document accurately reflects the priorities and needs of our health systems. We believe that the result is a much-improved document that sets the stage for a much better, comprehensive, and well thought our system of care for Alaska Natives and American Indians.

The unfortunate issue is that, while the Act lays out a tremendous vision of what is possible, funding for pursuing this vision remains far, far under what is needed to even begin to meet the goals of the system. It is only right and fair that the first peoples of this proud country get the services they are entitled to as a result of many, many government to government agreements over the years.

We at SCF and ANMC, and many other locations across Indian Country, have demonstrated that we have the expertise and the motivation to provide outstanding services with inadequate funding. We ask that the Improvement Act be passed as we have presented it and that adequate funding be provided to implement it and give us a reasonable chance of bringing the health indicators in Indian Country to at least the level of the rest of the country. It is only right and only fair. We are capable of great things. We have proven it.

Southcentral Foundation

Further Testimony on the reauthorization of the Indian Healthcare Improvement Act

Answers to further questions from Senator Ben Nighthorse Campell sent to me on May 24, 2000 in response to testimony delivered by me on May 10, 2000

Douglas Eby MD MPH FAAFP
Southcentral Foundation
Anchorage, Alaska
June 14, 2000

Introduction

Thank you again for the tremendous opportunity to discuss with you what we have done as a tribal health corporation providing health services through funding from I.H.S. and other sources. We strongly believe in the customer-owner model of health care made possible by compacting. We are proud to be able to provide you with an example of why the reauthorization of the Indian Healthcare Improvement Act and further marked expansion of funding for these programs is a good investment in addition to being a right of American Indians and Alaska Natives.

I am responding once again on behalf of the SCF Board of Directors, my CEO – Katherine Gottlieb MBA, and the leadership and staff of Southcentral Foundation. I am responding to the follow-up questions sent me after my May10th testimony. It is an honor to be given the opportunity to provide you with further information. I look forward to your ongoing interest and support of our efforts to work with the Native [illegible] move towards health and wellness.

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1. Why is a community and relationship based system so important to Alaska Natives?

There are many reasons – most are not specific to Alaska Natives and a few are. If you are truly trying to use your healthcare system to move towards health and wellness, not just the treatment of disease, then health education and lifestyle change are critically important. Health education research and publications are full of examples where the education could produce change that was sustained for months, but seldom is there real demonstrable effect long-term. The exceptions are in those settings where the education is based in a long-term provider-patient relationship where the educational messages can be reinforced over time and where trust between provider and patient is high.

Trust is a critical piece of successful healthcare. Often the most trusted health advisors are the patient's non-medical friends. The reason is trust and more openness to share what is 'really' going on. In a healthcare system that is community based and does everything possible to create ongoing relationship between patient and provider, trust builds and builds resulting in the patient being more willing to open up and get to 'deeper' issues that underlie true health and wellness. The patient also trusts the information and recommendations from the provider more since they create a long-term relationship.

One final general fact is that patients get really tired of repeating their health history to every new provider and nurse they see. When you get to the core issues that annoy people about the healthcare system, this is a big one. It also means that when you start at the beginning each time, you only have time to deal with the superficial, immediate issues and the true determinants of health – those underlying issues – never get touched.

Native cultures in Alaska (and elsewhere) have a strong emphasis on family and community. The individual draws identity more from family and community than from self. Native values understand that happiness, success, and wellness are difficult if not pursued in family, community, and long-term relationship.

For any healthcare system to become successful, it must be appropriate for, and sensitive to, the culture(s) within which it functions. A Native healthcare system must be community and family oriented or it will never reach the levels of success that are possible. In Native communities you first build connection and relationship and then you do your business. It is a relationship based way of living. The healthcare system for this community must be built around these same valued to be successful.

In summary, we have patients, families, and whole communities that relate to us for their whole life – for generations! We are customer-owned and managed. We are a healthcare system in a community that values community, family, and relationship highly. We have the opportunity in this type of setting to do what few health systems can. We can build long-term individual, family, and community relationships in a healthcare setting that truly give us the opportunity to get to the core issues that build health and wellness. It is

an opportunity that must be, and is in some locations, recognized in order to be used to the benefit of those who use this healthcare system.

2. Why do you feel it is important to have Alaska Natives involved in every level of operation of your facility/system?

About 7 years ago the US Congress appointed an Alaska Native Task Force. It was composed of primarily Alaska Native leaders and a few non-Native appointees. The task force produced a large, three volume written summary about all issue facing Alaska Natives. It addressed such things as housing, transportation, education, employment, resource development, subsistence lifestyle, and many other issues in addition to health. After all was said and done the executive summary of this major project said one issue rose above all others and was central to the long-term success of Alaska Native peoples. That issue was dependency. Through the military, government programs of many types, education systems, missionaries, and, yes, the healthcare system, it was the opinion of this knowledgeable group that breaking the cycle of dependency was critical.

In the past healthcare systems have created dependency everywhere. Fortunately this has improved a lot over time, but it remains an issue everywhere. I.H.S. systems run from a central office very distant from the service delivery locations, historically led by non-Native individuals, with doctors and nurses who mostly go in Indian Country for short periods of time, are naturally going to further dependency issues. Indian Self-Determination and the recruitment of more and more Indian/Native individuals into healthcare clinical positions and professional management at all levels has gone a long way towards remedying these issues.

A critical way to work at issues of dependency is to provide training and employment. It is also to provide Native role models and every increasing opportunities for advancement and to build confidence and capability. Some of the most critical ways that the system can help build health and wellness in the Native community is through the development of Native staff. They become leaders and role models in their family, their immediate community, and the larger Native community. Their sense of capability and confidence extends to those around them and inspires others to reach higher and move towards less dependent lifestyles.

The other level of Native involvement in healthcare is at the patient and family level. In SCF's mission/vision/key points statements the first key point is 'Shared Responsibility'. SCF believes that we are partners with the individual, family, and community, working with them to help them with issues related to health and wellness. We actively seek doctors and other staff who are a good 'fit' for us – not just those with the most impressive credentials. We are serious about finding professionals and developing all of our staff with an emphasis on helping the patient, family, and community be able to do more and more for themselves and take control of their own health issues. Self care is not a new concept and is more and more prevalent across the country, but we make it a

particularly strong emphasis in our system. It is what our customer-owners want and it is a very strong way to get at issues of dependency, illness, health, and wellness.

There are also some more specific cultural issues. Alaska Native ways tends towards quiet listening, just 'being' with someone, not directly confronting individuals, waiting patiently, and sensing the spirit of others. These are broad generalities with many exceptions, but generally true nonetheless. There is a lot that 'outsiders' can learn, but it is a slow process and one can never completely become 'Native' if not Native.

There is therefore a tremendous advantage to having leadership and staff that are Native. It is more likely that they will just 'know' the right way to be and to relate as they work in a healthcare setting. Trust and relationship are more quickly built. This is critically important to the success of any healthcare system, as addressed in question #1.

In summary, by emphasizing a system that encourages patient self-care, Native hire and development, and continual focus on our patients and our staff, we can help in the struggle against dependency and the movement towards health and wellness. Our structures, our corporate culture, and our service delivery systems must be intentionally planned and built around these priorities. It is the only way that makes sense in our setting.

3. Can you give some examples of how that (integration of Traditional Healing) works?

Traditional healing can be talked about in two pieces for the purposes of discussion (although such a division is somewhat artificial). There are traditional ways that promote health and healing and are widely practiced. There are also specific individuals that others look to as 'Traditional Healers' or 'Tribal Doctors'.

We incorporate Traditional ways into many of our programs in both intentional and unintentional ways. Our residential treatment program for substance abusing pregnant women emphasizes reconnecting with Native ways and uses many Traditional approaches and activities. Our 'Young Warriors' groups for adolescents uses many traditional activities. All of are many mental health programs use many Traditional methods and activities. Even in our research activities we use Traditional ways.

At present we employ one Tribal Doctor or Traditional Healer. She works directly in our medical outpatient facility and works in close conjunction with our medical staff. For the most part they refer patients back and forth, but do jointly consult on some patients. We have had this actively in place for only a year, but consider it very successful and wish to expand it. At present our medical staff have found it a positive experience.

Healthcare systems that exist in the US at present are for the most part focused on physical illness and wellness. These healthcare systems do some work with mental health, but often in a 'separated out' way. These systems do little around spiritual

wellness. Our Traditional Healing part of what we do gives us expertise and tools to use that expands our ability to deal with spiritual, emotional, and mental aspects of health, illness, and wellness. It increases our ability to deal with the whole person as a whole person.

4. Why is an integrated system so important?

Patients are tired of having to go from place to place for artificially divided pieces of who they are. They are tired of telling their story over and over again. They are tired of having multiple providers for one family. They are tired of the left hand not knowing what the right hand is doing in what is supposed to be one system of care.

We have declared that the whole system will work in ways that make sense to the patient. Much further detail of what we have done is available in my written testimony provided on May 10th.

The reason this matters is improved quality of care and extending our dollars as far as we can. The Native health system of this country is woefully underfunded. Critical health needs are going unmet. With such limited funding we must find ways to take the dollars we do have and stretch them as far as possible. We can provide much more service for the same funding if we create an intentional, planned, coordinated system where duplication of effort is minimized, hand-offs are smooth, and the patient gets the right thing at the right time, in a way that they find pleasing.

The other reason is quality and patient safety. There is increasing awareness across this country that quality is uneven and patient safety is compromised in way too many instances. By creating an intentional planned system of care you can markedly improve quality and decrease errors that endanger the patient. This is a very big topic worthy of a very long discussion, but suffice it to say that systems of care with careful attention to quality and safety in a the very complex healthcare arena are far better and safer than systems that leave it to individual capability.

5. How have you funded your Primary Care Center and its expansion?

We have done this facility expansion through a number of creating ways. We have strongly benefited from our connections to our for-profit corporate 'parent' – CIRI (Cook Inlet Region Inc.). They built the initial facility and then later sold it to us. They have provided considerable real estate and building expertise for us on an ongoing basis.

We have use municipal bonds to finance many of the costs. As a not-for-profit corporation we have access to this type of funding source and have used it well.

We have worked closely with the municipality and other community agencies to build alliances across our system of care. This has helped with community grants and planning and zoning issues as they have arisen.

We have also very closely and carefully managed our resources. As a compacted tribe working in a not-for-profit corporate environment we have used our ability to chart our own course to our benefit. We have highly capable finance leadership and staff who have dramatically affected our sophistication in funding our many projects.

6. (Access challenges for same day service at satellite locations)

We provide same day access at all of our locations. We have a satellite clinic in Anchorage that is a partnership with the local non-Native community health center. We contribute to the operation of the clinic in such a way that our patients are guaranteed the same extent of access as in our central location.

The other locations we discussed briefly during the verbal questions on May 10th affected the villages. There are 55 villages in the Anchorage Service Unit, for which we are the physician-based hub. These are remote villages mostly accessible only by small planes. We do provide these persons with exactly the same type of access if they can get to Anchorage. Our system also assists with travel money for most health-related travel from the villages. We also provide continual, all day phone access for the health aides who are based in these villages seeing patients.

So, we do provide immediate access for any and all primary care needs across all locations in our system of care. It just varies in exactly how that is accomplished from location to location.

Final Comments

Thank you once again for the opportunity to share with you what we have been able to accomplish at Southcentral Foundation. We believe in taking the funds we are able to obtain and making an outstanding system of care to the extent that funding allows. We are confident we can provide a quality product with whatever amount of funding we can obtain. The extent of the service is what will be limited by the amount of funding.

We strongly agree with other testimony you have heard that the level of funding provided to Indian Country is woefully inadequate. We strongly support the Indian Healthcare Reauthorization Act and the comprehensive picture of a good healthcare system it paints. We also strongly support funding adequate to fulfill the vision of this document.

We believe we are a strong example of what success can look like in a Self-Determination, customer-owner environment when an unrelenting commitment to quality and to the customer is present and an continual search for better ways of providing healthcare is taken on. We are proud of what we are doing and invite any of you who wish to better understand what we have been able to do to visit us or talk with us further.

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