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S. HRG. 108–204

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

S. 556

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

JULY 23, 2003
WASHINGTON, DC

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REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, JULY 23, 2003

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

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

Present: Senators Campbell, Johnson, and Murkowski.

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

The CHAIRMAN. The Committee on Indian Affairs will be in session.

Welcome to the third hearing in a series held by the Committee on S. 556, a bill to Reauthorize the Indian Health Care Improvement Act. Today we will hear from tribal leaders and tribal health care experts on issues related to Indian access to health care and services. The committee will receive testimony on how Indian access is affected by Medicare, Medicaid, and other Federal health care programs, and what improvements are needed to increase Indian access.

[Text of S. 556 follows:]

II

108TH CONGRESS
1ST SESSION

S. 556

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

IN THE SENATE OF THE UNITED STATES

MARCH 6, 2003

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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Indian Health Care Improvement Act Reauthorization of 2003".

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

Sec. 1. Short title.

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

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

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

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

Subtitle B—Medicaid

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

Subtitle C—State Children's Health Insurance Program

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

Subtitle D—Authorization of Appropriations

Sec. 231. Authorization of appropriations.

TITLE III—MISCELLANEOUS PROVISIONS

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

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

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

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

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"Sec. 101. Purpose.
"Sec. 102. General requirements.
"Sec. 103. Health professions recruitment program for Indians.
"Sec. 104. Health professions preparatory scholarship program for Indians.
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"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

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"Sec. 202. Catastrophic Health Emergency Fund.
"Sec. 203. Health promotion and disease prevention services.
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"Sec. 205. Shared services.
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''SEC. 2. FINDINGS.

''Congress makes the following findings:

''(1) Federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the

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

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

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

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

''(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than

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

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

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

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

"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

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

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

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

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

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

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

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

"SEC. 4. DEFINITIONS.

"In this Act:

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

"(2) AREA OFFICE.—The term 'area office' means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

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

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

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

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

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

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

cine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, and allied health professions, or any other health profession.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(B) is an Eskimo or Aleut or other Alaskan Native;

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

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

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

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

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"SEC. 101. PURPOSE.

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

"SEC. 102. GENERAL REQUIREMENTS.

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

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

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

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

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

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

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

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

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

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

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

"(A) to enroll in courses of study in such health professions; or

"(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

"(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

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

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

''(b) ADMINISTRATIVE PROVISIONS.—

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

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

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

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

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

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

''(1) irrespective of whether such individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940;

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

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

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

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

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

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

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

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

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

"(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act) except that an extension of up to 2 years may be approved by the Secretary.

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

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

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

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

"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

"(a) SCHOLARSHIPS.—

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

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

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

''(b) ELIGIBILITY.—

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

''(2) SERVICE OBLIGATION.—

''(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year for year obligation, by service—

''(i) in the Indian Health Service;

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

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

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

"(B) DEFERRING ACTIVE SERVICE.—At the request of any Indian who has entered into a contract referred to in subparagraph (A) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

"(i) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of

obligated service that is required under this section.

"(ii) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

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

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

"(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

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

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

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

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

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

"(ii) two years; and

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

"(4) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with the area office pursuant to a scholarship under this section and who—

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

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

"(iii) voluntarily terminates the training in such an educational institution for

which he or she is provided a scholarship under such contract before the completion of such training; or

"(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract;

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A) an individual breaches his or her written contract by failing either to begin such individual's service obligation under this section or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

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

"(D) WAIVER.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the appropriate area office, Indian tribe, tribal organization, and urban Indian organization, determines that—

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

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

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

"(E) HARDSHIP OR GOOD CAUSE.—Notwithstanding any other provision of law, in any

case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

"(F) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

"(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.—

"(1) PROVISION OF FUNDS.—

"(A) IN GENERAL.—The Secretary shall make funds available, through area offices, to Indian tribes and tribal organizations for the purpose of assisting such tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

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

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

"(2) REQUIREMENTS.—

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

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

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

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

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

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

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

"(i) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

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

"(B) provide that the scholarship—

"(i) may only be expended for—

"(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

"(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B), such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

"(ii) may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the

year for the purposes authorized in clause (i);

"(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

"(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to the health profession involved.

"(5) BREACH OF CONTRACT.—

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

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

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

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

"(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract;

shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A), an individual breaches his or her written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified

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

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

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

"(A) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

"(B) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the

State agency that administers the State plan for medical assistance under title XIX of such Act to provide service to individuals entitled to medical assistance under the plan.

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

"SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

"(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various colleges and universities throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

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

"(c) REQUIREMENTS.—

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

"(2) PROGRAM.—Applicants for funds under this section shall agree to provide a program which, at a minimum—

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

"(B) incorporates a program advisory board comprised of representatives from the

tribes and communities that will be served by the program;

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

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

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

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

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

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

"(1) in the Indian Health Service;

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

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

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

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship.

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

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

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

"(d) ADMINISTRATIVE PROVISIONS.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

"SEC. 108. CONTINUING EDUCATION ALLOWANCES.

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

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

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

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

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

and disease prevention services to Indian communities.

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

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

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

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

"(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

"(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion,

and disease prevention and maintain programs that meet the needs for such continuing education;

''(4) maintain a system that provides close supervision of community health representatives;

''(5) maintain a system under which the work of community health representatives is reviewed and evaluated; and

''(6) promote traditional health care practices of the Indian tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

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

''(a) ESTABLISHMENT.—

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

''(2) DEFINITIONS.—In this section:

"(A) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

"(i) directly by the Service;

"(ii) by any Indian tribe or tribal or Indian organization pursuant to a funding agreement under—

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

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

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

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

"(b) ELIGIBILITY.—To be eligible to participate in the Loan Repayment Program, an individual must—

"(1)(A) be enrolled—

"(i) in a course of study or program in an accredited institution, as determined by the Secretary, within any State and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

"(ii) in an approved graduate training program in a health profession; or

"(B) have—

"(i) a degree in a health profession; and

"(ii) a license to practice a health profession in a State;

"(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

"(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

"(C) meet the professional standards for civil service employment in the Indian Health Service; or

"(D) be employed in an Indian health program without a service obligation; and

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

"(c) FORMS.—

"(1) IN GENERAL.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Indian Health Service to enable the individual to make a decision on an informed basis.

"(2) FORMS TO BE UNDERSTANDABLE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

"(3) AVAILABILITY.—The Secretary shall make such application forms, contract forms, and other in-

formation available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

"(d) PRIORITY.—

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

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

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

"(2) PRIORITY IN APPROVAL.—Notwithstanding the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

"(A) give first priority to applications made by individual Indians; and

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

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

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

"(e) CONTRACTS.—

"(1) IN GENERAL.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

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

"(A) the Secretary's approving of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

"(B) the Secretary's disapproving an individual's participation in such Program.

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

"(1) an agreement under which—

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

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

"(ii) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a tribe, tribal organization, or urban Indian organization as provided in subparagraph (B)(iii); and

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

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

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

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

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

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

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

"(3) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent

upon funds being appropriated for loan repayments under this section;

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

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

"(g) LOAN REPAYMENTS.—

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

"(A) tuition expenses;

"(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

"(C) reasonable living expenses as determined by the Secretary.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act) on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

"(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

"(ii) provides an incentive to serve in Indian health programs with the greatest shortages of health professionals; and

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of

obligated service under the Loan Repayment Program.

"(B) TIME FOR PAYMENT.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made not later than the end of the fiscal year in which the individual completes such year of service.

"(3) SCHEDULE FOR PAYMENTS.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

"(h) COUNTING OF INDIVIDUALS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be counted against any employment ceiling affecting the Department.

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

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

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

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

"(2) give priority to assigning individuals to Indian health programs that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

"(l) BREACH OF CONTRACT.—

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

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

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

"(ii) voluntarily terminates such enrollment; or

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

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

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

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

cover from such individual an amount to be determined in accordance with the following formula:

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

in which—

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

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

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

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

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

"(3) DAMAGES.—

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

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

"(i) utilize collection agencies contracted with by the Administrator of the General Services Administration; or

"(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

"(C) CONTRACTS FOR RECOVERY OF DAMAGES.—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United

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

"(m) CANCELLATION, WAIVER OR RELEASE.—

"(1) CANCELLATION.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

"(2) WAIVER OF SERVICE OBLIGATION.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(3) WAIVER OF RIGHTS OF UNITED STATES.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship or other good cause shown, as determined by the Secretary.

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

ruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

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

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

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

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

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

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

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

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

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

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

"(a) ESTABLISHMENT.—Notwithstanding section 102, there is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

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

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

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

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

Amounts appropriated to the LRRF shall remain available until expended.

"(b) USE OF LRRF.—

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

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

"(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached

the contract entered into under section 105 or section 110.

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

"(c) INVESTING OF FUND.—

"(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

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

"SEC. 112. RECRUITMENT ACTIVITIES.

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

urban Indian organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

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

"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

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

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

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

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

"(b) SERVICE OBLIGATION.—

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

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

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

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

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

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

"(1) public or private schools of nursing;

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

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

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

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

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

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

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

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

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

"(c) APPLICATIONS.—Each application for funds under subsection (a) shall include such information as the

Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

"(d) PREFERENCES.—In providing funds under subsection (a), the Secretary shall extend a preference to—

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

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

"(3) programs that are interdisciplinary; and

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

"(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

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

"(1) in the Indian Health Service;

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

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

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

"SEC. 116. TRIBAL CULTURE AND HISTORY.

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

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

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

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

"(3) include instruction in Native American studies.

"SEC. 117. INMED PROGRAM.

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

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

subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

"(c) REQUIREMENTS.—

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

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

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

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

"(C) provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions;

"(D) provides tutoring, counseling and support to students who are enrolled in a health career program of study at the respective college or university; and

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

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

"(a) ESTABLISHMENT GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on an Indian reservation, in the Service, or in a tribal health program.

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

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

"(b) CONTINUATION GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

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

"(A) is accredited;

"(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

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

"(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

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

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

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

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

"(c) SERVICE PERSONNEL AND TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

"(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs, and

"(2) providing technical assistance and support to such colleges.

"(d) SPECIFIED COURSES OF STUDY.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses

of study which provide advanced training for any health professional who—

"(1) has already received a degree or diploma in such health profession; and

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

Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

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

"(f) DEFINITIONS.—In this section:

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

"(A) a tribally controlled community college; or

"(B) a junior or community college.

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

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

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

"SEC. 119. RETENTION BONUS.

"(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

"(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

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

"(3) has—

"(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban organization; or

"(B) completed any service obligations incurred as a requirement of—

"(i) any Federal scholarship program; or

"(ii) any Federal education loan repayment program; and

"(4) enters into an agreement with the Service, Indian tribe, tribal organization, or urban Indian organization for continued employment for a period of not less than 1 year.

"(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

"(c) FAILURE TO COMPLETE TERM OF SERVICE.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(l)(2)(B).

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

health professional is serving in a position which the Secretary determines is—

"(1) a position for which recruitment or retention is difficult; and

"(2) necessary for providing health care services to Indians.

"SEC. 120. NURSING RESIDENCY PROGRAM.

"(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 110(a)(2)(A)), and have done so for a period of not less than 1 year, to pursue advanced training.

"(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse) or an advanced degree in nursing and public health.

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

obligation to serve in an Indian health program for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

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

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

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

"(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

"(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Aide Program under subsection (a), shall—

"(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

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

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

"(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

"(C) promotes the achievement of the health status objective specified in section 3(b);

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

munity health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or who can demonstrate equivalent experience;

''(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

''(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

''(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.

''SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

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

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

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

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

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

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

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

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

"SEC. 124. SCHOLARSHIPS.

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

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

"SEC. 125. NATIONAL HEALTH SERVICE CORPS.

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

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

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

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

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

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

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

"(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

"(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

"(c) TERM OF GRANT.—A contract entered into or a grant provided under this section shall be for a period

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

"(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

"(e) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

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

"(g) DEFINITIONS.—In this section:

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

"(A) Classroom education.

"(B) Clinical work experience.

"(C) Continuing education workshops.

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

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

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

"(a) STUDY AND LIST.—

"(1) IN GENERAL.—The Secretary and the Secretary of the Interior in consultation with Indian tribes and tribal organizations shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications in-

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

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

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

"(i) elementary and secondary education;

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

"(iii) law enforcement and judicial services; and

"(iv) alcohol and substance abuse;

"(B) staff positions within the Service; and

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

"(3) TRAINING CRITERIA.—

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

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

"(4) CULTURAL RELEVANCY.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

"(5) COMMUNITY EDUCATION.—

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

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

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

"(b) STAFFING.—

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

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

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

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

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

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

''(2) eliminating backlogs in the provision of health care services to Indians;

''(3) meeting the health needs of Indians in an efficient and equitable manner;

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

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

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

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

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

"(C) dental care;

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

"(E) emergency medical services;

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

"(G) accident prevention programs;

"(H) home health care;

"(I) community health representatives;

"(J) maintenance and repair; and

"(K) traditional health care practices.

"(b) USE OF FUNDS.—

"(1) LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act, the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

"(2) ALLOCATION.—

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

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

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

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

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

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

"(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

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

"(3) REVIEW OF DETERMINATION.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such tribe or tribal organization.

"(d) ELIGIBILITY.—Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

"(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit to the Congress the current health status and resource deficiency report of the Service for each

Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

"(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

"(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service;

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

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service, for the preceding fiscal year which is allocated to each service unit, Indian tribe, or comparable entity;

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

"(C) the number of Indians using the Service resources made available to each service unit or Indian tribe or tribal organization, and,

to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

''(f) BUDGETARY RULE.—Funds appropriated under the authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

''(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs or to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

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

''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—

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

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

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

"(2) ADMINISTRATION.—The CHEF shall be administered by the Secretary solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

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

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

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

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

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

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

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

''(A) for 1999, not less than $19,000; and

''(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United

States city average) for the 12-month period ending with December of the previous year;

"(3) establish a procedure for the reimbursement of the portion of the costs incurred by—

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

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

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

"(4) establish a procedure for payment from the CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(5) establish a procedure that will ensure that no payment shall be made from the CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

"(c) LIMITATION.—Amounts appropriated to the CHEF under this section shall not be used to offset or limit appropriations made to the Service under the author-

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

"(d) DEPOSITS.—There shall be deposited into the CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from the CHEF.

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

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

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

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

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

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

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

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

"(A) controlling—

"(i) diabetes;

"(ii) high blood pressure;

"(iii) infectious agents;

"(iv) injuries;

"(v) occupational hazards and disabilities;

"(vi) sexually transmittable diseases; and

"(vii) toxic agents; and

"(B) providing—

"(i) for the fluoridation of water; and

"(ii) immunizations.

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

"(A) raising people's awareness about health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information;

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

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

"(D) making available suitable housing, safe water, and sanitary facilities;

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

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

"(G) adequate and appropriate programs including—

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

"(ii) community health;

"(iii) community safety;

"(iv) consumer health education;

"(v) diet and nutrition;

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

"(vii) environmental health;

"(viii) exercise and physical fitness;

"(ix) fetal alcohol disorders;

"(x) first aid and CPR education;

"(xi) human growth and development;

"(xii) injury prevention and personal safety;

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

"(xiv) personal health and wellness practices;

"(xv) personal capacity building;

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

"(xvii) psychological well being;

"(xiii) reproductive health (family planning);

"(xix) safe and adequate water;

"(xx) safe housing;

"(xxi) safe work environments;

"(xxii) stress control;

"(xxiii) substance abuse;

"(xxiv) sanitary facilities;

"(xxv) tobacco use cessation and reduction;

"(xxvi) violence prevention; and

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

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

"(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement which is required to be submitted to Congress under section 801 an evaluation of—

"(1) the health promotion and disease prevention needs of Indians;

"(2) the health promotion and disease prevention activities which would best meet such needs;

"(3) the internal capacity of the Service to meet such needs; and

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

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

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

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

of complications resulting from, diabetes among Indians; and

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

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

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

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

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

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

''(1) in each area office of the Service, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

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

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

"SEC. 205. SHARED SERVICES.

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

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

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

"(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

"(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal facility be allocated proportionately between the Service and the tribe or tribal organization; and

"(3) may authorize such tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

"(c) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

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

"SEC. 206. HEALTH SERVICES RESEARCH.

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

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

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

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

"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

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

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

"(2) Other cancer screening meeting national standards.

"SEC. 208. PATIENT TRAVEL COSTS.

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

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

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

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

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

"SEC. 209. EPIDEMIOLOGY CENTERS.

"(a) ESTABLISHMENT.—

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

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

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

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

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

"(C) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

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

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

"(F) provide requested technical assistance to Indian tribes and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

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

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

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

"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

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

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

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

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

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

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

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

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

"(7) develop mental health wellness programs;

"(8) develop chronic disease prevention programs;

"(9) develop substance abuse prevention programs;

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

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

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

"(13) carry out violence prevention activities; and

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

"(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian tribes, tribal organizations and urban Indian organizations in the development of comprehensive health education plans, and the dissemination of comprehensive health education materials and information on existing health programs and resources.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian orga-

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

"(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

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

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

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

"(B) mental health wellness programs;

"(C) chronic disease prevention programs;

"(D) substance abuse prevention programs;

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

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

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

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

"(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

"(C) encourage healthy, tobacco-free school environments.

"SEC. 211. INDIAN YOUTH PROGRAM.

"(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to provide funding to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—Funds made available under this section may be used to—

"(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

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

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

"(c) REQUIREMENTS.—The Secretary shall—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(1) hospice care and assisted living;

"(2) long-term health care;

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

"(4) public health functions; and

"(5) traditional health care practices.

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

"(c) DEFINITIONS.—In this section:

"(1) HOME- AND COMMUNITY-BASED SERVICES.—The term 'home- and community-based services' means 1 or more of the following:

"(A) Homemaker/home health aide services.

"(B) Chore services.

"(C) Personal care services.

"(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

"(E) Training for family members.

"(F) Adult day care.

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

"(2) HOSPICE CARE.—The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of such care.

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

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

"The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

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

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

"(2) an analysis of the potential effect of ongoing and future environmental resource development on or near Indian reservations and communities including the cumulative effect of such development over time on health;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal, oil and gas production or transportation on or near Indian reservations or communities, and other development that could affect the health of Indians and their water supply and food chain;

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

"(5) a description of the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

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

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

"(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

"(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

"(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

"(c) SUBMISSION TO CONGRESS.—

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

"(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address the health problems involved.

"(d) TASK FORCE.—

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

"(A) The Secretary of Energy.

"(B) The Administrator of the Environmental Protection Agency.

"(C) The Director of the Bureau of Mines.

"(D) The Assistant Secretary for Occupational Safety and Health.

"(E) The Secretary of the Interior.

"(2) DUTIES.—The Task Force shall identify existing and potential operations related to nuclear resource development or other environmental haz-

ards that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community, and enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

"(3) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

"(e) PROVISION OF APPROPRIATE MEDICAL CARE.—In the case of any Indian who—

"(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work related illness or condition;

"(2) is eligible to receive diagnosis and treatment services from a Service facility; and

"(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard;

the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

"SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2015, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of Arizona.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

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

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of North Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of North Dakota.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of North Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

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

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 2003, and ending with the fiscal year ending September 30, 2015, the State of South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of South Dakota.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of South Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).

"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM.

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

"(b) REIMBURSEMENT OF BOARD.—

"(1) AGREEMENT.—The Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred pursuant to this section in providing medical treatment under contract to California Indians described in section 809(b) throughout the California contract health services delivery area described in section 218 with respect to high-cost contract care cases.

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

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

"(3) LIMITATION.—No payment may be made for treatment provided under this section to the extent that payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

"(c) ADVISORY BOARD.—There is hereby established an advisory board that shall advise the California Rural Indian Health Board in carrying out this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under this section, at least 50 percent of whom are not affiliated with the California Rural Indian Health Board.

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

"The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San

Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State, except that any of the counties described in this section may be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

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

"(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

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

''The Service shall provide funds for health care programs and facilities operated by Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act on the same basis as such funds are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

''Health care professionals employed by Indian tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

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

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

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

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

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

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

"SEC. 224. LIABILITY FOR PAYMENT.

"(a) NO LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

"(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services.

"(c) LIMITATION.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall

have no further recourse against the patient who received the services involved.

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE III—FACILITIES

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

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

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

"(2) ensure, whenever practicable, that such facility meets the construction standards of any nationally recognized accrediting body by not later

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

"(b) CLOSURE OF FACILITIES.—

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

"(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

"(B) the cost effectiveness of such closure;

"(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

"(D) the availability of contract health care funds to maintain existing levels of service;

"(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

"(F) the level of utilization of such hospital or facility by all eligible Indians; and

"(G) the distance between such hospital or facility and the nearest operating Service hospital.

"(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

"(c) PRIORITY SYSTEM.—

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

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

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

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

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

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

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

"(B) health care facility lists, including—

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

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

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

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

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

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

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

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

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

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

Indian Self-Determination and Education Assistance Act; and

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

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

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

"(d) REVIEW OF NEED FOR FACILITIES.—

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

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

"(2) CONSULTATION.—In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

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

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

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

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

"(f) INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes, tribal organizations and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those

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

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

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

"(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal facilities is primarily a health consideration and function;

"(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

"(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

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

"(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water sup-

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

"(b) PROVISION OF FACILITIES AND SERVICES.—

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

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

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

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

tions which operate and maintain sanitation facilities; and

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

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

"(A) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

"(B) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

"(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(h) REPORT.—

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

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

"(B) the methodology for determining sanitation deficiencies;

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

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

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

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

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

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

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

"(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs.

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

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

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

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

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

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

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

"(i) DEFINITIONS.—In this section:

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

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

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

"(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water

and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

"(1) ownership and control by Indians;

"(2) equipment;

"(3) bookkeeping and accounting procedures;

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

"(5) adequately trained personnel; or

"(6) other necessary components of contract performance.

"(b) EXEMPTION FROM DAVIS-BACON.—For the purpose of implementing the provisions of this title, construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are exempt from the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act). For all health facilities, staff quarters and sanitation facilities, construction and renovation subcontractors shall

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

"SEC. 304. SOBOBA SANITATION FACILITIES.

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

"SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

"(a) PERMISSIBILITY.—

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

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

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

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

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

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

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

"(1) the tribe or tribal organization—

"(A) provides notice to the Secretary of its intent to expand, renovate or modernize; and

"(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel or equipment; and

"(2) the expansion renovation or modernization—

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

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

"(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FACILITY TO BE USED AS A SERVICE FACILITY.—If any Service facility which has been expanded, renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal

program that were expended for such expansion, renovation or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation or modernization.

"SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

"(a) AVAILABILITY OF FUNDING.—

"(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to tribes and tribal organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided for in subsections (b)(2) and (c)(1)(C)). Funding under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

"(2) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or con-

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

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—Funds provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

''(A) located apart from a hospital;

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

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

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

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

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

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

"(c) APPLICATION AND PRIORITY.—

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

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

"(A) adequate financial support will be available for the provision of services at such facility;

"(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

"(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

"(2) PRIORITY.—In awarding funds under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

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

"(B) insufficient capacity to deliver such services.

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

which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian tribe or tribal organization.

"(e) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

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

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

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

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

"(1) waive any leasing prohibition;

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

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

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

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

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

"(c) CRITERIA.—

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

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

"(B) A significant number of Indians, including those with low health status, will be served by the project.

"(C) The project has the potential to address the health needs of Indians in an innovative manner.

"(D) The project has the potential to deliver services in an efficient and effective manner.

"(E) The project is economically viable.

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

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

"(2) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such ap-

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

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

"(A) Cass Lake, Minnesota.

"(B) Clinton, Oklahoma.

"(C) Harlem, Montana.

"(D) Mescalero, New Mexico.

"(E) Owyhee, Nevada.

"(F) Parker, Arizona.

"(G) Schurz, Nevada.

"(H) Winnebago, Nebraska.

"(I) Ft. Yuma, California.

"(d) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

"(e) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-

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

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

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

"SEC. 308. LAND TRANSFER.

"(a) GENERAL AUTHORITY FOR TRANSFERS.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost,

land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

"(b) CHEMAWA INDIAN SCHOOL.—The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.

"SEC. 309. LEASES.

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

"(b) FACILITIES FOR THE ADMINISTRATION AND DELIVERY OF HEALTH SERVICES.—The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

"(1) title to;

"(2) a leasehold interest in; or

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

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

"(c) FUNDING.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(a) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian tribes and tribal organizations to establish joint venture demonstration projects under which an Indian tribe or tribal organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility.

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

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

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

"(b) REQUIREMENTS.—

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

"(A) the Secretary first determines that the Indian tribe or tribal organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in subsection (a)(1); and

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

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

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

retary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe or tribal organization, or paid to a third party on the tribe's or tribal organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence shall not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

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

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

"SEC. 313. LOCATION OF FACILITIES.

"(a) PRIORITY.—The Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

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

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

"(2) any lands title to which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power; and

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

"SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

"(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

"(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

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

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

"(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

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

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

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

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

''(a) ESTABLISHMENT OF RENTAL RATES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates under paragraph (1), an Indian tribe or tribal orga-

nization shall attempt to achieve the following objectives:

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

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

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

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

"(b) COLLECTION OF RENTS.—

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

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

"(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

"(C) Such rent payments shall be retained by the Indian tribe or tribal organization and shall not be made payable to or otherwise be deposited with the United States.

"(D) Such rent payments shall be deposited into a separate account which shall be used by the Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

"(2) RETROCESSION.—If an Indian tribe or tribal organization which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally-owned quarters, such retrocession shall become effective on the earlier of—

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

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

"(c) RATES.—To the extent that an Indian tribe or tribal organization, pursuant to authority granted in subsection (a), establishes rental rates for federally-owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rent-

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

"SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

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

"(b) FALSE OR MISLEADING LABELING.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to the authorization contained in section 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

"(c) DEFINITION.—In this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office

Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

"SEC. 317. OTHER FUNDING FOR FACILITIES.

''Notwithstanding any other provision of law—

''(1) the Secretary may accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design and construct health care facilities for Indians and to place such funds into funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

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

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

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

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

''SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE IV—ACCESS TO HEALTH SERVICES

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

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

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

''(c) SPECIAL FUND.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such

amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

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

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

"(a) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally re-

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

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

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

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

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

''SEC. 403. REPORT.

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

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

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

"(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

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

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

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

"(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

"(1) determine the population of Indians to be served that are or could be recipients of benefits or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

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

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

"(4) develop and implement—

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

"(B) methods of improving the participation of Indians in receiving the benefits and assistance provided under titles XVIII, XIX, and XXI of the Social Security Act.

"(c) AGREEMENTS FOR RECEIPT AND PROCESSING OF APPLICATIONS.—The Secretary may enter into an agreement with an Indian tribe or tribal organization, or an urban Indian organization, which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act and benefits under title XVIII of such Act by a Service facility or a health care program administered by such Indian tribe or tribal organization, or urban Indian organization, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act or a grant or contract entered into with an urban Indian organization under title V of this Act. Notwithstanding any other provision of law, such agreements shall provide for reimbursement of the cost of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may be included in an encounter rate or be made on a fee-for-service basis as appropriate for the provider. When necessary to carry out the terms of this section, the Secretary, acting through the Health Care Fi-

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

"(d) GRANTS.—

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

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

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

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

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

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

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

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

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

"(a) ESTABLISHMENT OF DIRECT BILLING PROGRAM.—

"(1) IN GENERAL.—The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Service under the Indian Self-Determination and Education Assistance Act may elect to directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), under the medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or from any other third party payor.

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

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

"(b) DIRECT REIMBURSEMENT.—

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

"(A) solely for improving the health resources deficiency level of the Indian tribe; and

"(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

"(2) AUDITS.—The amounts paid to the hospitals and clinics participating in the program established under this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act.

"(3) SECRETARIAL OVERSIGHT.—The Secretary shall monitor the performance of hospitals and clinics participating in the program established under this section, and shall require such hospitals and clinics to submit reports on the program to the Secretary on an annual basis.

"(4) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a), no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or

clinic participates in the program established under this section.

"(c) REQUIREMENTS FOR PARTICIPATION.—

"(1) APPLICATION.—Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—

"(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;

"(B) the facility is eligible to participate in the medicare or medicaid programs under section 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);

"(C) the facility meets the requirements that apply to programs operated directly by the Service; and

"(D) the facility—

"(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or

"(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.

"(2) APPROVAL.—

"(A) IN GENERAL.—The Secretary shall review and approve a qualified application not later than 90 days after the date the application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.

"(B) GRANDFATHER OF DEMONSTRATION PROGRAM PARTICIPANTS.—Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 2000 shall be deemed approved for participation in the program established under this section and shall not be required to submit an application in order to participate in the program.

"(C) DURATION.—An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved

applicant or the deemed approved demonstration program meets the requirements of this section.

"(d) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement—

"(A) any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under title XIX of the Social Security Act; and

"(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.

"(2) ACCOUNTING INFORMATION.—The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 2000. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

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

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

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

"(1) such services had been provided by a nongovernmental provider; and

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

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

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

"(1) workers' compensation laws; or

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

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

"(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery provided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

"(f) METHODS OF ENFORCEMENT.—

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

"(A) intervening or joining in any civil action or proceeding brought—

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

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

"(B) instituting a civil action.

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

"(g) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United

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

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

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

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

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

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

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

"SEC. 407. CREDITING OF REIMBURSEMENTS.

"(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87–693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

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

"SEC. 408. PURCHASING HEALTH CARE COVERAGE.

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

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

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

"(3) a health insurance provider.

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

"(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

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

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

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

"(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

"(1) the priority access of any Indian to health care services provided through the Service;

"(2) the quality of health care services provided to any Indian through the Service;

"(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

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

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

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

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

"SEC. 410. PAYOR OF LAST RESORT.

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

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

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

"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

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

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

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

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

"SEC. 413. ACCESS TO FEDERAL INSURANCE.

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

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

"SEC. 414. CONSULTATION AND RULEMAKING.

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

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

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

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

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

"SEC. 415. LIMITATIONS ON CHARGES.

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

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

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

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

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

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

"Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

"(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

"(1) any Indian tribe or tribal organization or an urban Indian organization that administers

health programs under the authority of the Indian Self-Determination and Education Assistance Act;

"(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

"(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2003); or

"(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of this Act (as so in effect), or other applicable law, to pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization;

provided the exchange arises from or relates to such health programs.

"(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act

or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

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

"(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an Indian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an In-

dian tribe or tribal organization or an urban Indian organization and another health provider.

"(b) EXEMPTION FROM PREMIUMS.—

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

"(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

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

"SEC. 421. ESTATE RECOVERY PROVISIONS.

"Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

"(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

"(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

"(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

"(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

"SEC. 422. MEDICAL CHILD SUPPORT.

"Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization. For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

"(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization or an urban Indian organization shall have a right of recovery under section

408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian tribe or tribal organization or an urban Indian organization.

"(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement may not be made a prerequisite for such payments to be made.

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

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

"(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

"(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

"(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under

1 any managed care entity participating in a State plan
2 under title XIX or XXI of the Social Security Act unless
3 the Indian had the option of enrolling in a managed care
4 plan or health program administered by the Service, an
5 Indian tribe or tribal organization, or an urban Indian or-
6 ganization.

7 "(h) INDIAN MANAGED CARE PLANS.—Notwith-
8 standing any other provision of law, any State entering
9 into agreements with one or more managed care organiza-
10 tions to provide services under title XIX or XXI of the
11 Social Security Act shall enter into such an agreement
12 with the Service, an Indian tribe or tribal organization or
13 an urban Indian organization under which such an entity
14 may provide services to Indians who may be eligible or
15 required to enroll with a managed care organization
16 through enrollment in an Indian managed care organiza-
17 tion that provides services similar to those offered by other
18 managed care organizations in the State. The Secretary
19 and the State are hereby authorized to waive requirements
20 regarding discrimination, capitalization, and other matters
21 that might otherwise prevent an Indian managed care or-
22 ganization or health program from meeting Federal or
23 State standards applicable to such organizations, provided
24 such Indian managed care organization or health program

offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

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

"SEC. 424. NAVAJO NATION MEDICAID AGENCY.

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

"(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

"(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

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

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

"(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

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

"SEC. 425. INDIAN ADVISORY COMMITTEES.

"(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

"(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the

Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

"SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2015 to carry out this title.''.

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"SEC. 501. PURPOSE.

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

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within urban centers, of programs which meet the requirements set forth in this title. The Secretary, through the Service, subject to section 506, shall include

such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

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

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

"(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

"(2) estimate the current health status of urban Indians residing in such urban center or centers;

"(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

"(4) provide basic health education, including health promotion and disease prevention education, to urban Indians;

"(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

"(6) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

"(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

"(1) the extent of unmet health care needs of urban Indians in the urban center or centers involved;

"(2) the size of the urban Indian population in the urban center or centers involved;

"(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

"(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

"(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center or centers; and

"(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

"(c) HEALTH PROMOTION AND DISEASE PREVENTION.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a).

"(d) IMMUNIZATION SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or pro-

vide, immunization services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

"(e) MENTAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) to provide outreach, educational, and referral services to urban Indians regarding the availability of direct behavioral health services, to educate urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to urban Indians;

"(C) to provide outpatient behavioral health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment; and

"(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

"(f) CHILD ABUSE.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts

entered into pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

"(C) to provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

"(4) CONSIDERATIONS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

"(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

"(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

"(C) the assessment required under paragraph (2).

"(g) MULTIPLE URBAN CENTERS.—The Secretary, acting through the Service, may enter into a contract with,

or make grants to, an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to urban Indians in more than one urban center.

"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

"(a) AUTHORITY.—

"(1) IN GENERAL.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503.

"(2) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary

has entered into a contract with, or made a grant to, under this section.

"(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake to—

"(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

"(B) with respect to urban Indians in the urban center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

"(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

"(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

"(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title and compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) COMPLIANCE WITH TERMS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

"(1) conduct, through the Service, an annual onsite evaluation of the organization; or

"(2) accept, in lieu of an onsite evaluation, evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the medicare program under Title XVIII of the Social Security Act.

"(c) NONCOMPLIANCE.—

"(1) IN GENERAL.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

"(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with such organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract or grant is not renewed under this section.

"(d) DETERMINATION OF RENEWAL.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has com-

pleted performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

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

"(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

"(1) be made in their entirety by the Secretary to the urban Indian organization by not later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

"(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the expenditure of such funds.

"(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

"(d) FAIR AND UNIFORM PROVISION OF SERVICES.—Contracts with, or grants to, urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

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

"SEC. 507. REPORTS AND RECORDS.

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

"(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

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

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary, after consultations consistent with section 514, with urban Indian organizations.

"(b) AUDITS.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(c) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

"(1) a certified public accountant; or

"(2) a certified public accounting firm qualified to conduct Federal compliance audits.

"SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

"The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

"SEC. 509. FACILITIES.

"(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

"(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

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

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

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

"(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the revenue of the organization as security for a loan or loan guarantee under this subsection.

"(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

"(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

"(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

"(A) such amounts as may be appropriated to the URLF;

"(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

"(C) interest earned on amounts in the URLF under paragraph (3).

"(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

"(3) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet

current withdrawals from the URLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

''There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to urban Indian organizations.

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

''(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom

the Secretary has entered into a contract under this title or under section 201.

"(b) GOALS OF GRANT.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the—

"(1) size of the urban Indian population;

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

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

"(4) identification of need for services.

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

"(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance

abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

"(a) TULSA AND OKLAHOMA CITY CLINICS.—Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall become permanent programs within the Service's direct care program and continue to be treated as service units in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

"(b) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects specified in subsection (a).

"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

"(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2004, with urban Indian or-

ganizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section to as 'NIAAA') and transferred to the Service.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

''SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with

urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

''(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

''SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

''For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting

from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian organization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

"(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting.

"(b) STATES.—A State described in this subsection is a State in which—

"(1) there reside urban Indian youth with a need for alcohol and substance abuse treatment services in a residential setting; and

"(2) there is a significant shortage of culturally competent residential treatment services for urban Indian youth.

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

"(a) IN GENERAL.—The Secretary shall permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within

the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

"(b) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

"(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

"(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian tribe or tribal organization, the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization if the Secretary receives the request from the Indian tribe

or tribal organization before the date on which the Secretary transfers title to the property or, if earlier, the date on which the Secretary transfers the property physically, to the urban Indian organization.

"(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

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

"(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed upon between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

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

"(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

"(3) performance standards for the urban Indian organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

"(4) the capability of the urban Indian organization to adequately perform the activities required under the grant; and

"(5) the willingness of the urban Indian organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the area office of the Service in which the organization is located.

"(d) APPLICATION OF CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

"SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

"The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

"SEC. 520. REGULATIONS.

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

"(b) PROMULGATION.—

"(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

"(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270

days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

"(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursuant to section 565 of title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

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

"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

"(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

"(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

"(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

"(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

"(4) all scholarship and loan functions carried out under title I.

"(d) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

"(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

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

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

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

the Service as a result of its establishment under subsection (a).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

"(a) ESTABLISHMENT.—

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

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

"(A) a financial management system;

"(B) a patient care information system;

"(C) a privacy component that protects the privacy of patient information;

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

"(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

"(2) meet the management information needs of the Service.

"(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

"(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—It is the purpose of this section to—

''(1) authorize and direct the Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs;

''(2) provide information, direction and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement and judicial services;

"(3) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

"(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

"(5) ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access; and

"(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(b) BEHAVIORAL HEALTH PLANNING.—

"(1) AREA-WIDE PLANS.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for In-

dian Behavioral Health Services. The plans shall, to the extent feasible, include—

"(A) an assessment of the scope of the problem of alcohol or other substance abuse, mental illness, dysfunctional and self-destructive behavior, including suicide, child abuse and family violence, among Indians, including—

"(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; and

"(ii) an estimate of the financial and human cost attributable to such illness or behavior;

"(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

"(C) an estimate of the additional funding needed by the Service, Indian tribes, tribal organizations and urban Indian organizations to meet their responsibilities under the plans.

"(2) NATIONAL CLEARINGHOUSE.—The Secretary shall establish a national clearinghouse of

plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such plans and outcomes by any Indian tribe, tribal organization, urban Indian organization or the Service.

"(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be utilized and adopted locally.

"(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

"(1) a comprehensive continuum of behavioral health care that provides for—

"(A) community based prevention, intervention, outpatient and behavioral health aftercare;

"(B) detoxification (social and medical);

"(C) acute hospitalization;

"(D) intensive outpatient or day treatment;

"(E) residential treatment;

"(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

"(G) emergency shelter;

"(H) intensive case management;

"(I) traditional health care practices; and

"(J) diagnostic services, including the utilization of neurological assessment technology; and

"(2) behavioral health services for particular populations, including—

"(A) for persons from birth through age 17, child behavioral health services, that include—

"(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

"(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (multiple diagnosis);

"(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

"(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

"(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

"(vii) co-morbidity services;

"(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

"(i) early intervention, treatment and aftercare services;

"(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

"(iv) healthy choices and life style services (related to parenting, partners, do-

mestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

"(v) female specific treatment services for—

"(I) women at risk of giving birth to a child with a fetal alcohol disorder;

"(II) substance abuse requiring gender specific services;

"(III) sexual assault and domestic violence; and

"(IV) healthy choices and life style (parenting, partners, obesity, suicide and other related behavioral risk); and

"(vi) male specific treatment services for—

"(I) substance abuse requiring gender specific services;

"(II) sexual assault and domestic violence; and

"(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

"(C) family behavioral health services, including—

"(i) early intervention, treatment and aftercare for affected families;

"(ii) treatment for sexual assault and domestic violence; and

"(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

"(D) for persons age 56 years and older, elder behavioral health services including—

"(i) early intervention, treatment and aftercare services that include—

"(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

"(III) healthy choices and life style services (managing conditions related to aging);

"(ii) elder women specific services that include—

"(I) treatment for substance abuse requiring gender specific services and

"(II) treatment for sexual assault, domestic violence and neglect;

"(iii) elder men specific services that include—

"(I) treatment for substance abuse requiring gender specific services; and

"(II) treatment for sexual assault, domestic violence and neglect; and

"(iv) services for dementia regardless of cause.

"(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

"(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and

family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

"(2) TECHNICAL ASSISTANCE.—In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

"(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

"(e) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organiza-

tions, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

"(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

"SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

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

"(2) the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

"(3) the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

"(4)(A) the right of Indians, as citizens of the United States and of the States in which they reside, to have access to mental health services to which all citizens have access;

"(B) the right of Indians to participate in, and receive the benefit of, such services; and

"(C) the actions necessary to protect the exercise of such right;

"(5) the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

"(6) a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

"(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and

"(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

"(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to community

behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412); and

"(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

"(b) SPECIFIC PROVISIONS.—The memorandum of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

"(1) the determination of the scope of the problem of alcohol and substance abuse among Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

"(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

"(3) an estimate of the funding necessary to adequately support a program of prevention of alco-

hol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

''(1) Indian tribes and tribal organizations;

''(2) Indian individuals;

''(3) urban Indian organizations and other Indian organizations;

''(4) behavioral health service providers.

''(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Federal Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including systems

of care and traditional health care practices, which shall include—

"(A) prevention, through educational intervention, in Indian communities;

"(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

"(C) community-based rehabilitation and aftercare;

"(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

"(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children;

"(F) diagnostic services utilizing, when appropriate, neuropsychiatric assessments which include the use of the most advances technology available; and

"(G) a telepsychiatry program that uses experts in the field of pediatric psychiatry, and that incorporates assessment, diagnosis and

treatment for children, including those children with concurrent neurological disorders.

"(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

"(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

"SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

"(1) provides for the training of Indians as mental health technicians; and

"(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

"(b) TRAINING.—In carrying out subsection (a)(1), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

"(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

"(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section involves the utilization and promotion of the traditional

Indian health care and treatment practices of the Indian tribes to be served.

"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

"Subject to section 220, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

"(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling psychologist;

"(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

"(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

"(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

"(b) USE OF FUNDS.—Funding provided pursuant to this section may be used to—

"(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

"(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

"(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

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

"(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 707. INDIAN YOUTH PROGRAM.

"(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

"(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment

center or treatment network in each area under the jurisdiction of an area office.

"(B) AREA OFFICE IN CALIFORNIA.—For purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

"(2) FUNDING.—For the purpose of staffing and operating centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

"(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) that is agreed upon (by appropriate tribal resolution) by a majority of the tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska;

"(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l));

"(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

"(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treat-

ment Center, a residential youth treatment facility in New Mexico.

"(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youth residing in such State.

"(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations, may provide intermediate behavioral health services, which may incorporate traditional health care practices, to Indian children and adolescents, including—

"(A) pre-treatment assistance;

"(B) inpatient, outpatient, and after-care services;

"(C) emergency care;

"(D) suicide prevention and crisis intervention; and

"(E) prevention and treatment of mental illness, and dysfunctional and self-destructive

behavior, including child abuse and family violence.

"(2) USE OF FUNDS.—Funds provided under this subsection may be used—

"(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

"(B) to hire behavioral health professionals;

"(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided; and

"(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

"(E) to provide intensive home- and community-based services, including collaborative systems of care.

"(3) CRITERIA.—The Secretary shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of ap-

plications or proposals for funding made available pursuant to this subsection.

"(d) FEDERALLY OWNED STRUCTURES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

"(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youth; and

"(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

"(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

"(e) REHABILITATION AND AFTERCARE SERVICES.—

"(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and implement within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

"(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate.

1 Not less than 10 percent of the funds appropriated for
2 the purposes of carrying out subsection (e) shall be used
3 for outpatient care of adult family members related to the
4 treatment of an Indian youth under that subsection.

5 ''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
6 acting through the Service, Indian tribes, tribal organiza-
7 tions and urban Indian organizations, shall provide, con-
8 sistent with section 701, programs and services to prevent
9 and treat the abuse of multiple forms of substances, in-
10 cluding alcohol, drugs, inhalants, and tobacco, among In-
11 dian youth residing in Indian communities, on Indian res-
12 ervations, and in urban areas and provide appropriate
13 mental health services to address the incidence of mental
14 illness among such youth.

15 **"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL**
16 **HEALTH FACILITIES DESIGN, CONSTRUCTION**
17 **AND STAFFING ASSESSMENT.**

18 ''(a) IN GENERAL.—Not later than 1 year after the
19 date of enactment of this section, the Secretary, acting
20 through the Service, Indian tribes and tribal organiza-
21 tions, shall provide, in each area of the Service, not less
22 than 1 inpatient mental health care facility, or the equiva-
23 lent, for Indians with behavioral health problems.

24 ''(b) TREATMENT OF CALIFORNIA.—For purposes of
25 this section, California shall be considered to be 2 areas

of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

''(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

''(a) COMMUNITY EDUCATION.—

''(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each service unit or tribal program a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community.

''(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

"(3) TRAINING.—Community-based training (oriented toward local capacity development) under a program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

"(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders, to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

"(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol

and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

"(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

"(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 710. BEHAVIORAL HEALTH PROGRAM.

"(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

"(1) Whether the project will address significant unmet behavioral health needs among Indians.

"(2) Whether the project will serve a significant number of Indians.

"(3) Whether the project has the potential to deliver services in an efficient and effective manner.

"(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

"(5) Whether the project will deliver services in a manner consistent with traditional health care.

"(6) Whether the project is coordinated with, and avoids duplication of, existing services.

"(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

"(a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the pur-

poses of meeting the health status objective specified in section 3(b).

"(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

"(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

"(B) identify and provide behavioral health treatment to high-risk women;

"(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

"(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

"(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

"(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

"(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

"(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

"(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

"(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

"(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

"(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the

special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

''(c) TASK FORCE.—

''(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

''(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

''(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian

tribes, tribal organizations and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol disorders.

"(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

"(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

"(1) victims of child sexual abuse; and

"(2) perpetrators of child sexual abuse.

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

"(1) develop and provide community education and prevention programs related to child sexual abuse;

"(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

"(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

"(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

"(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated, and to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

"SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

"(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to Indian tribes, tribal organizations and urban Indian organizations or, enter into

contracts with, or make grants to appropriate institutions, for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

"(1) the inter-relationship and inter-dependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

"(2) the development of models of prevention techniques.

"(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

"SEC. 714. DEFINITIONS.

"In this title:

"(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis and dissemination of information on health status, health needs and health problems.

"(2) ALCOHOL RELATED NEURODEVELOPMENTAL DISORDERS.—The term 'alcohol related

neurodevelopmental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(4) BEHAVIORAL HEALTH AFTERCARE.—

"(A) IN GENERAL.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse

or mental health outpatient or outpatient treatment, to help prevent or treat relapse, including the development of an aftercare plan.

"(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

"(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.

"(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

"(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be met:

"(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

"(B) Craniofacial abnormalities with at least 2 of the following: microphthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

"(C) Prenatal or postnatal growth delay.

"(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means a history of maternal alcohol consumption during pregnancy having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

"(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.

"(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

"SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE VIII—MISCELLANEOUS

"SEC. 801. REPORTS.

"The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—

"(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population, including specific comparisons of appropriations provided and those required for such parity;

"(2) a report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the allocation of funding pursuant to section 808;

"(3) a report on the use of health services by Indians—

"(A) on a national and area or other relevant geographical basis;

"(B) by gender and age;

"(C) by source of payment and type of service;

"(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

"(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

"(4) a report of contractors concerning health care educational loan repayments under section 110;

"(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

"(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

"(7) a report on infectious diseases as required under section 212;

"(8) a report on environmental and nuclear health hazards as required under section 214;

"(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

"(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

"(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

"(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

"(13) a report providing an accounting of reimbursement funds made available to the Secretary

under titles XVIII and XIX of the Social Security Act as required under section 403(a);

"(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

"(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

"(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

"(17) a report on the evaluation of programs as required under section 513; and

"(18) a report on alcohol and substance abuse as required under section 701(f).

"SEC. 802. REGULATIONS.

"(a) INITIATION OF RULEMAKING PROCEDURES.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act.

"(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

"(b) RULEMAKING COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian tribes, and tribal organizations, a majority of whom shall be nominated by and be representatives of Indian tribes, tribal organizations, and urban Indian organizations from each service area.

"(c) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian tribes.

"(d) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

"(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

"SEC. 803. PLAN OF IMPLEMENTATION.

"Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

"SEC. 804. AVAILABILITY OF FUNDS.

"Amounts appropriated under this Act shall remain available until expended.

"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

"Any limitation on the use of funds contained in an Act providing appropriations for the Department for a pe-

riod with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(A) Any member of a federally recognized Indian tribe.

"(B) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(i) is a member of the Indian community served by a local program of the Service; and

"(ii) is regarded as an Indian by the community in which such descendant lives.

"(C) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(D) Any Indian in California who is listed on the plans for distribution of the assets of

California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(b) RULE OF CONSTRUCTION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

"(a) INELIGIBLE PERSONS.—

"(1) IN GENERAL.—Any individual who—

"(A) has not attained 19 years of age;

"(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

"(C) is not otherwise eligible for the health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has

been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

"(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

"(b) PROGRAMS AND SERVICES.—

"(1) PROGRAMS.—

"(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other

subsection of this section or under any other provision of law if—

"(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

"(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

"(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

"(II) there is no reasonable alternative health program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

"(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under

such funding agreement is authorized to determine whether health services should be provided under such funding agreement to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

"(2) LIABILITY FOR PAYMENT.—

"(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880 of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the

account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

"(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent person.

"(3) SERVICE AREAS.—

"(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing

body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

"(c) PURPOSE FOR PROVIDING SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

"(1) achieve stability in a medical emergency;

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

"(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or

"(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

"(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

"(e) DEFINITION.—In this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

"SEC. 808. REALLOCATION OF BASE RESOURCES.

"(a) REQUIREMENT OF REPORT.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a service unit may be implemented only after the Secretary has submitted to the

President, for inclusion in the report required to be transmitted to the Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

''SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

''SEC. 810. PROVISION OF SERVICES IN MONTANA.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr. 1987).

''(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

"During the period of the moratorium imposed by Public Law 100–446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

"For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, Chapter 372), an Indian tribe or tribal organization carrying out a funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

"For purposes of section 4 of Public Law 102–585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be deemed to be an executive agency and part of the Service and, as such, may act as an ordering agent of the Service

and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

"(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

"(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

"(1) Ten members of Congress, of which—

"(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

"(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

"(C) two members shall be from the Senate and shall be appointed by the majority leader; and

"(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the pro-

vision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

"(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected by the Indian tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

"(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian tribes.

"(c) TERMS.—

"(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

"(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

"(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

"(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

"(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

"(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian tribes;

"(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

"(A) to the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian tribes, tribal organizations and urban Indian organizations, and which may include authorizing and funding feasibility studies of various models for providing and funding health services for all Indian beneficiaries including those who live outside of a reservation, temporarily or permanently;

"(B) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provided, and the

cost, including mechanisms for funding of the health services to be provided;

"(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

"(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

"(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

"(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

"(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a

recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

''(e) ADMINISTRATIVE PROVISIONS.—

''(1) COMPENSATION AND EXPENSES.—

''(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), while serving on the business of the Commission (including travel time) shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States

Code, and while so serving away from home and the member's regular place of business, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(2) MEETINGS AND QUORUM.—

"(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

"(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

"(3) DIRECTOR AND STAFF.—

"(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

"(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

"(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

"(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

"(E) FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals

required for the proper functioning of the Commission.

"(f) POWERS.—

"(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, except that at least 6 regional hearings shall be held in different areas of the United States in which large numbers of Indians are present. Such hearings shall be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this paragraph, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established under this section may be counted towards the number of regional hearings required by this paragraph.

"(2) STUDIES BY GAO.—Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

"(3) COST ESTIMATES.—

"(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

"(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

"(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal Agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

"(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal Agency shall provide such technical assistance to the

Commission as the Commission determines to be necessary to carry out its duties.

"(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal Agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

"(7) OBTAINING INFORMATION.—The Commission may secure directly from the any Federal Agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

"(8) SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

"(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

''SEC. 815. APPROPRIATIONS; AVAILABILITY.

''Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

''SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

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

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period and inserting '', and''; and

(3) by adding at the end the following:

''(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.''.

SEC. 202. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

''QUALIFIED INDIAN HEALTH PROGRAM

''SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

"(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by—

"(A) the Indian Health Service;

"(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; or

"(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

"(2) INCLUDED PROGRAMS AND ENTITIES.—Such term may include 1 or more hospital, nursing home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

"(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under

this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

"(c) DETERMINATION OF PAYMENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

"(2) DEFINITION OF FULL COST RECOVERY.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

"(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into account the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

"(ii) indirect costs which, in the case of a qualified Indian health program—

"(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

"(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

"(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

"(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

"(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

"(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

"(B) NO SINGLE REPORT REQUIREMENT.—Not all qualified Indian health programs provided or administered by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

"(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report

shall be made on a fee-for-service, encounter, or per diem basis.

"(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

"(A) a significant decrease in discharges;

"(B) costs for graduate medical education programs;

"(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

"(D) payment for outlier cases.

"(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

"(A) on the full cost recovery basis provided in paragraphs (1) through (5);

"(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

"(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

"(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian tribe or tribal organization; or

"(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

"(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

"(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal

organization, or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

"(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

"(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

"(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health set-

ting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

''(C) preventive primary health services as described under section 330 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

''(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screening, diagnostic, and treatment services as described in section 1905(r);

''(E) influenza and pneumococcal immunizations;

''(F) other immunizations for prevention of communicable diseases when targeted; and

''(G) the cost of transportation for providers or patients necessary to facilitate access for patients.''.

Subtitle B—Medicaid

SEC. 211. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (64), by striking ''and'' at the end:

(2) in paragraph (65), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (65), the following:

''(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

''(A) the term 'meaningful consultation' is defined through the negotiated rulemaking

process provided for under section 802 of the Indian Health Care Improvement Act; and

"(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.".

SEC. 212. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

"Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.".

SEC. 213. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

"INDIAN HEALTH SERVICE PROGRAMS

"SEC. 1911. (a) IN GENERAL.—The Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan by such entities if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable generally to the service for which it seeks reimbursement under this title and for services provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be

deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations, or urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.".

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking "For purposes" and inserting the following:

"(1) IN GENERAL.—Subject to paragraph (2), for purposes"; and

(2) by adding at the end the following:

"(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).".

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting "an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)," after "Service,".

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

"(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

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

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

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

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2004 through 2015 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

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

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions

to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

SEC. 303. EFFECTIVE DATE.

This Act and the amendments made by this Act take effect on October 1, 2003.

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The CHAIRMAN. In the interest of time, we are going to go ahead and start with our panel which includes Melanie Benjamin, chief executive, Mille Lacs Band Assembly, Onamia, MN; Buford L. Rolin, vice chairman, Poarch Band of Cree Indians, Atmore, AL; Myra M. Munson, Esq., Sonosky, Chambers, Sachse, Miller & Munson, LLP, Juneau, AK; and Mim Dixon, Dixon & Associates, Boulder, CO.

I read all your written testimony this morning. It will all be included in the record. If you would like to abbreviate or diverge from that written testimony, feel free to do so.

We will start with Ms. Benjamin.

STATEMENT OF MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND ASSEMBLY, ONAMIA, MN, ACCOMPANIED BY SAMUEL MOOSE, COMMISSIONER OF HEALTH AND HUMAN SERVICES

Ms. BENJAMIN. Good morning, Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Committee on Indian Affairs. I am Melanie Benjamin. I am the chief executive of the Mille Lacs Band of Ojibwe. Accompanying me today is Samuel Moose, who is the commissioner of Health and Human Services. I also brought summer youth as well. This will be their first opportunity to participate in this hearing.

The CHAIRMAN. Are those the young people back here?

Ms. BENJAMIN. Yes.

The CHAIRMAN. We are glad to have them here.

Ms. BENJAMIN. The Mille Lacs Band is a federally-recognized tribe of 3,570 members located in East Central Minnesota. As an elected tribal leader, I have an interest in the general direction of Federal Indian policy. I am greatly concerned with the dismal state of health across Indian country, and in particular, on the Mille Lacs Reservation.

My comments to the Senate Committee on Indian Affairs are provided from this perspective. At the outset, I wish to respectfully point out that I am not an expert on health care issues, nor on Medicaid or Medicare. There are individuals on this panel who are experts and possess the technical knowledge to more adequately address these subjects.

Today I will briefly discuss three topics as they relate to Medicaid and Medicare under Title IV of the Indian Health Care Improvement Act, sovereignty, the Federal trust responsibility, and Indian Health disparities. The access to health services under title IV provisions have a direct connection to the health disparities in Indian country and must be addressed by Congress.

When the Indian Health Care Improvement Act was first enacted in 1976, Congress recognized its trust responsibility toward the tribes to provide adequate health care. Throughout the subsequent amendments and reauthorizations of the act, one of the major underlying policies has been to provide tribes access to other Federal health care sources, like Medicaid and Medicare programs that do not face funding limits like our Indian Health Service programs do.

The intent was and is to improve our health status through that access. Since then Medicaid and Medicare reimbursement to tribes,

including the Mille Lacs Band, have become a significant source of revenue for our health care programs and operations.

Over the last 15 years, the Mille Lacs Band has actively participated in the formulation of tribal self-governance policy. We were one of the first 10 self-governance tribes. We participated in the original demonstration project and the writing of the permanent acts for BIA and Indian Health Service self-governance. We have also been on the rulemaking committees for the implementation of self-governance laws.

Currently, the Mille Lacs Band is an active member of the Tribal Self-Governance Advisory Committee that advises Federal agencies on Indian policy matters affecting the self-governance tribes. The Mille Lacs Band has supported and advocated for self-governance laws because our philosophy is that we should be free to govern ourselves and develop our own policies in the administration of our tribal programs. We should not be entangled by Federal or State bureaucracy. To us, developing our own policies is an important exercise of sovereignty.

There are three principles that the Mille Lacs Band of Ojibwe considers when analyzing Federal programs. First, we assert that our primary relationship is with the Federal Government. Second, we retain all sovereignty not expressly taken away. Therefore, we should have the ability to control funds reserved for us under Federal law. Third, we should have equal access to the same funding avenues as States. This third principle raises the fundamental flaw of the Medicaid and Medicare programs and the treatment of tribes.

It is my understanding that the design of the Medicaid and Medicare programs is a Federal-State collaboration. The problem is that tribes do not fit into the picture at all. This design flaw makes it very difficult to meet criteria for receiving reimbursements.

An example is that counties receive an administrative match from the State for their administrative costs, while tribes cannot. According to the Mille Lacs Band of Ojibwe's Commission of Health and Human Services, our inability to recover the administrative match demonstrates that tribes do not have equal access to Medicaid and Medicare reimbursements.

The reason is that States determine how their block grants will be distributed under their own guidelines. As a result, the Mille Lacs Band and many other tribes lose out on potential and critical avenues of funding we desperately need. Others on this panel have addressed this and other legal barriers more specifically, but from a tribal leader perspective, it is clear that States and managed care systems have predominance over tribes under Medicaid and Medicare.

Clearly, the establishment of Medicaid and Medicare entitlement programs happened at a time in history when the Congress did not focus on tribal sovereignty. However, today tribes are treated as governments in Federal legislation and tribal sovereignty is recognized. Indian people are provided direct access to Federal programs and funding.

The Mille Lacs Band of Ojibwe receives direct funding for our Self-Governance Indian Health Service annual funding agreement. But when it comes to Medicaid and Medicare programs, it is a dif-

ferent situation. The process of devolution, where Federal funds in the form of block grants are provided to the States who then distribute those funds under their guidelines, has created a framework that leaves the tribes unable to access needed funds.

It is time to change the Medicaid and Medicare provisions under title IV of the Indian Health Care Improvement Act to reflect the new enlightened view of tribal sovereignty and provide tribes more access to health care services as the act was originally intended. Through our treaties, Federal statutes, executive orders, and court decisions, a Federal trust responsibility has been established and recognized over the course of dealings with tribes.

The Mille Lacs Band of Ojibwe signed several treaties with the United States and the provision of proper health care became an expectation of the Band and an obligation of the Federal Government. In addition, the Snyder Act of 1921, the Transfer Fact of 1954, the Self-Determination Act of 1975, the Indian Health Care Improvement of Act of 1976, as well as the enactment of the Indian Health Service Self-Governance Act, all evidence the trust obligations that flow to the tribes from the Federal Government for the provision of health care.

In spite of the clear legal duty created by these Federal statutes, the Federal obligation to provide adequate health care to tribes has never been properly funded. Historically, this insufficient funding has interfered with our ability to provide comprehensive health care to Mille Lacs Band members. According to IHS estimates, the Mille Lacs Band, and all other tribes in our region, are funded at approximately 30 percent of need. This means more than two-thirds of our need is not being met and explains why the status of Indian health on the Mille Lacs Band Reservation, and many other reservations, is so poor.

I am told that the Federal Government spends nearly twice as much for a prisoner's health care than it does for Indians. This fact is an example of why our health status is at the bottom of every disease category. It seems ironic that Indian health care, through the Indian Health Service, is not an entitlement for Indian people when tribes essentially pre-paid for our health care by ceding millions of acres of land to the Federal Government.

It seems more ironic that the tribes have problems accessing the Federal entitlement programs like Medicaid and Medicare which were designed for all State citizens. This funding disparity becomes a matter of fairness and equity because Indian people are also citizens of the States in which we reside. It is only logical that we should have the same access to the same services as do other non-Indian citizens.

Given that we have been historically under-funded for our health care needs, and tribes likely will not receive funding for the level of need in the next appropriations cycle, the Federal trust responsibility needs to be taken seriously and changes made to allow tribes full participation in the existing entitlement programs of Medicaid and Medicare. It is fair and it is right.

Finally, I am not going to cite the long and tragic list of statistics that tell the story of health disparities throughout Indian country. Instead, I will talk about my own Reservation. Diabetes is a serious problem in the Mille Lacs community. I do not know of one

family without diabetes among one of their family members. For many our Band members, it is not a matter of if they get the disease, but when. Band members are losing their vision. They are losing their limbs. Many are so close to needing kidney dialysis treatments.

More alarming is the chronic health conditions occurring in our children and our youth. They are our future. I have serious concerns for their long-term health and longevity. I do not have answers but I do know that adequate and comprehensive health care is absolutely critical to preserving our tribal communities. We are fighting to protect our members' lives on our reservations and in our communities.

If Congress makes the necessary changes to Title IV of the Indian Health Care Improvement Act, and provides more access to Federal health care services and funds, it will at least give us another weapon in the war against health disparities.

Thank you for this opportunity to testify. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

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

The CHAIRMAN. Thank you, Ms. Benjamin.

Senator Johnson, I do not know how tight your schedule is. Do you have a statement?

STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Mr. Chairman, I just commend you for holding this very timely hearing. There are few areas where we have a greater crisis than in health care as we go about the debate on Medicare and Medicaid within the context of prescription drug coverage. I think that we have made some real progress on the Senate side, but it is essential that we continue to be closely consultative with the tribes. I think you have an excellent panel here.

I am going to have to excuse myself for some conflicting obligations that I have, but I will be examining the testimony closely and look forward to working with you and other members of the committee to see what we can do. The overall level of funding, of course, is the first problem. The IHS is funded at roughly half of what they ought to be funded.

But even beyond that, I think it is proper that we focus on the role of Medicare-Medicaid third-party payment mechanisms and what we do to better utilize those resources to live up to our obligations in Indian country.

I thank you very much.

The CHAIRMAN. For the panel's information, members will be coming and going. Some will not be here. It does not mean they are not interested in the issue. Every one of us is over-scheduled with two or three things to do at the same time. It comes with the territory here. Please understand why some members are not here.

Let us go ahead with Buford Rolin. Thank you for being here.

STATEMENT OF BUFORD L. ROLIN, VICE CHAIRMAN, POARCH BAND OF CREEK INDIANS, ATMORE, AL

Mr. ROLIN. Thank you, Senator Campbell.

Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Committee on Indian Affairs, I am Buford Rolin, Vice Chairman of the Poarch Band of Creek Indians from Atmore, AL. I serve as an elected member of the National Indian Health Board representing the Nashville area. It is indeed an honor for me to come before you this morning to offer this testimony on the reauthorization of the Indian Health Care Improvement Act.

As you know, the Indian Health Service's National Indian Health Board serves all federally-recognized tribes throughout the Nation. We have a membership of 12 members that are elected to the Board by their respective areas. Our goal is to advocate for Indian people, not only in the budgetary area, but health issues throughout.

I would like to commend the testimony of chief executive officer Melanie Benjamin and her concerns. She has expressed them well. I know the other panelists will have equal concerns that they will talk about.

Given the two previous hearings of the committee that was held during the 108th Congress, I am going to be brief this morning. I realize that the members are quite aware, as you have just stated, about the needs of the health care of the Indian people, the reauthorization, and how important it is in the Indian Health Care Improvement Act. We realize the political realities that are facing Congress, and we appreciate the fact that you are holding these hearings this.

Let me talk a little bit about the process of what has taken place over the years since 1999 with the first bill that we introduced to reauthorize the Indian Health Care Improvement Act. In 1999, the National Steering Committee was formed by the Indian Health Service. It represented tribal leaders throughout the Nation as well as members from the organizations and urban areas.

Over the last several years, the NSC has worked closely with Indian country, the Administration and Congress, and the Indian Health Service to develop amendments to the Indian Health Care Improvement Act. Let me begin first by talking about the Centers for Medicaid and Medicare services.

At the request of the CMS, we have established a tribal technical work group that has been representative of Indian people throughout this Nation. The TTAG was formed in 2001 and consists of tribal leaders, area Indian health boards, and designated national tribal organizations.

The activities of the TTAG are coordinated through the Intergovernmental and tribal Affairs Office within CMS. The TTAG has forwarded several recommendations to Congress and CMS regarding recommended changes to the reimbursement methodologies in place for the Indian Health Service, tribal health programs, and urban Indian problems.

The TTAG is very adamant about its position that any reforms in Medicare, medicaid, or CHIP programs must allow for tribal al-

location or other direct funding mechanisms that authorize Indian health program access to CMS.

The TTAG has also worked very closely the NSC to develop the changes in Title IV of the Indian Health Care Improvement Act, as reflected in H.R. 2440, which include the most recent NSC recommendation.

As the committee is well aware, the Indian Health Service lags far behind other segments of the population and has failed to keep pace with inflation as far as health care is concerned. Current Indian Health Service funding is so inadequate that less than 60 percent of the health care needs of American Indians and Alaska Native people are being met.

In order to address additional health care resources, Title IV of the Indian Health Care Improvement Act is critical to address the Medicare-Medicaid and other third party reimbursements, as Chief Executive Officer Benjamin has stated this morning.

It is one of the most important provisions of the Indian Health Care Improvement Act. It makes IHS hospitals eligible for Medicare reimbursements and facilities eligible for Medicaid reimbursement. Title IV also makes it possible for Medicare and Medicaid eligible American Indians and Alaska natives to use these benefits.

Since the passage of the Indian Health Care Improvement Act in 1976, Medicare and Medicaid payments have become sources of income for tribal programs, so much so that in fiscal year 2002, $460 million was collected for these services. This amount enhances the resources available already to hospitals and clinics' budgets by 30 percent. We are indeed appreciative of that.

But in order to further improve the ability of Indian country as far as health providers to access third party resources, the NSC has developed several changes to title IV that was indicated in S. 212 and continues through S. 556. I would like to note that S. 556 introduced to Congress is identical to S. 212. Therefore, many of the concerns raised in regards to S. 212 remain.

In response to those concerns, however, the National Steering Committee has revised the recommendations for reauthorization. The changes are reflected in H.R. 2440. By the way, that bill was introduced June 11, 2003.

I think it is quite helpful to point out that the Senate Committee on Indian Affairs and the House Resources Committee's hearing on the Indian Health Care Improvement Act last week indicates the cooperation and the spirit of the two houses to support this reauthorization. H.R. 2440 reflects several changes made to the original tribal proposal as introduced in 1999. Those changes listed have come about and we will see that in H.R. 2440.

There are four areas that I would like to quickly talk about that we have been removed from the previous legislation. One is the Qualified Indian Health Program. This provision has been removed. We have requested that a provider type with Indian health programs appear, such as Medicaid, so that we can more fully exercise our statutory rights in that aspect.

Secretary Thompson expressed his concern for that in S. 212. His concern was that over a 10-year period it would cost in excess of $3 billion. However, in place of the QIHP proposal, tribes are requesting that the Secretary prepare a program or a report that

would, in fact, examine whether these payments under the current methodologies are sufficient to continue to be applicable as a most favorable provider under the Social Security Act. The current all-inclusive rate certainly is appreciated, and we would hope that in this process none of that would be discontinued.

Another concern that the Secretary had, of course, was the extension of the 100 percent Federal Medical Assistance Percentage. Tribal leaders agreed to delete this provision as well. The Centers for Medicare and Medicaid Services requested that be done. The States are very supportive of the 100 percent FMAP expansion. Secretary Thompson's concern was the cost of $2 billion over a 10-year period.

A third area of his concern was the waiver of the Medicare late enrollment penalty as far as Part B of Medicare is concerned and the barriers that it may create as far as giving Indians the opportunity to enroll late as opposed to other enrollees within the Medicare programs. Tribal leaders reluctantly agreed to remove that factor as well.

Finally, an area of concern that we had, and the Secretary objected to, was the fact that tribal leaders had asked for, and called for, regulations in a negotiated rulemaking process. Our concerns here were relative to the complexity of the Social Security Act and to having to negotiate a rulemaking process. In response to this concern again, tribal leaders eliminated the Social Security Act changes from the bill's negotiated rulemaking provision.

We believe the changes to the original tribal proposal submitted in 1999 significantly reduces the bill's Federal budget impact. S. 212, or its identical bill, S. 556, as it was scored in 2001, has a Federal budget impact of $6.9 billion. With the deletion of QIHP and the FMAP, the score reflects a 70-percent decrease.

We request, and ask this committee, to submit a request to the Congressional Budget Office to either score S. 556, without the above-mentioned provisions, provide a fiscal budget impact on H.R. 2440.

It has been my pleasure to brief this committee on the concerns that the National Indian Health Board has relative to the Indian Health Care Improvement Act. As I have been involved, along with other tribal leaders, including Chief Executive Officer Benjamin and the other panelists here this morning, we will continue to stay involved to make sure that this Act hopefully will be passed this year.

Further, we request that any concerns regarding this legislation are raised in a timely manner so that passage of the bill will occur during this session and there are no delays that would jeopardize the passage of this bill.

I thank you for your time. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

[Prepared statement of Buford Rolin appears in appendix.]

The CHAIRMAN. Thank you, Mr. Rolin.

Ms. Munson.

STATEMENT OF MYRA M. MUNSON, ESQUIRE, SONOSKY, CHAMBERS, SACHSE, MILLER & MUNSON, LLP, JUNEAU, AK

Ms. MUNSON. Thank you, Mr. Chairman.

The last time I had the privilege of testifying before this committee was in the late 1980's when I was still commissioner of Health and Social Services for the State of Alaska. Since joining the law firm I am a member of now, I have had the opportunity to work with tribal leaders and tribal health providers on every major health reform initiative that has been discussed in the Congress, and since 1998 when the work began on the reauthorization of the Indian Health Care Improvement Act.

It is fundamental that the United States owes a duty to Indians to provide them with health care. Everything flows from that. It is equally fundamental in the decisionmaking that that health care, in order to be delivered in a responsible way, must be culturally competent.

That requires not merely that individual Indians have access to health care, which most do not, at least in any way comparable to that of other citizens of the United States and the States, but it is important that the health care they have access to is that operated by their own tribes or the Indian Health Service, carried out to the extent possible to Indian people, and managed by Indian people.

Indian people and Indian tribes expected that the duty of the United States would be satisfied by providing them with direct appropriations to the Indian Health Service and eventually down to the tribes through the Self-Determination Act. Congress has not been able to effect the appropriations necessary to meet any level of health care for Indian people comparable to that, provided even to Federal employees, let alone to other Americans.

Instead, in 1976 when the Health Care Improvement Act was first authorized, Congress, realizing it could not meet the needs exclusively through direct appropriations, chose to authorize the Indian Health Service and tribes eventually as they took over the programs to bill for certain services provided to Medicare or Medicaid eligible Indians, to bill those programs and recover those revenues.

That made a fundamental shift and one which has been very difficult for tribes and for their members to absorb. It essentially made many Indians into welfare recipients when they had never been before. It made them apply for benefits through the Medicaid program in order to have access to the very care they had been promised and for which they had ceded their lands.

However, time passes and Indian people and Indian tribal leaders are pragmatic. Indian Health Services had to be pragmatic about this. The resistance to participating in those programs has had to be overcome simply to make enough money available to try to begin to provide for the needs for health care.

Tribes and the Indian Health Service have worked to become competent billers of the Medicare and Medicaid programs and to be able to participate without losing the integrity of the very special programs that they offer.

The Indian health system is truly the only system of health care that exists in the United States. For all the promise of managed

care, somehow it would bring a preventative focus to care; it would be a birth-to-death kind of model. In fact, it is as profit-driven as all other health care in the United States and tends to focus on illness and not on health, on response and not on prevention.

The Indian health system is fundamentally different than that in that it is truly a birth-to-death program. The people who are running health programs, and many of the programs that I work with, were born in the hospitals that they now operate and that they now run. Their children were born in those hospitals. They expect their great-grandchildren to be born and cared for in a program that they operate. That is not an expectation that those of us who rely on the private sector health care system care enjoy. But to make that real, of course, there must be adequate financing.

The Medicare and Medicaid programs are complex and not the things that are typically are dealt with by this committee or the Resources Committee in the House. They are relatively foreign. You may have experienced this yourself, or you may have talked with someone who has had to assist an elder parent in applying for Medicare or making sense of their benefits, or assisted someone in applying for Medicaid in order that they could be in a nursing home or get other care that they need—these are difficult programs to participate in.

In my written testimony, I have described very briefly the basics of those programs. I think for those of you who are, in fact, familiar with Indian people, and the way in which they live, when you read about those programs, you will see the way in which they diverge.

However, the Medicare and Medicaid programs are rife with special exceptions. There is a tendency to believe that it is all one program and it exists in exactly the same way for everyone. Fundamentally not true. There are exceptions built in throughout Medicare and Medicaid to assure that special populations will get some level of care to guarantee their access, and that certain kinds of providers will continue to exist even as the rates get cranked down in those programs to manage the cost increases.

So there are federally-qualified health centers, rural health centers, and critical access hospitals, children's hospitals, and cancer treatment centers. The list goes on and on of various kinds of specific providers, each one of which, if you meet all the finely-tuned rules, you get a special level of compensation under the program different than applies to others.

Fundamentally, as we worked on trying to revise the Medicare-Medicaid provisions and access by the Indian Health Service and tribes, we kept that in mind. We recognized that the duty to provide health care to Indians is fundamental. The existence of the Indian Health Service and of tribal health programs is fundamental. Medicaid and Medicare should recognize those special provider types.

As Mr. Rolin said, the Steering Committee agreed, reluctantly, to drop the qualified Indian Health Program as a new and special provider type in order to try to move this bill forward. Instead, what we have done is try to tailor very narrow provisions to other parts of Medicaid where there are special compensation or reimbursement rules or Medicare to permit the kinds of activities that

are so essential on reservations and in Indian communities in which health care is being provided.

For instance, there is a provision that allows visiting nurse services to be reimbursed, provided they are provided through a rural health center in a setting which is a shortage area for home and community-based care services. There are lots of rules attached to that. We ask that the same kind of visiting nurse services be reimbursed when they are provided in any Indian Health Service program without having to go through becoming a rural health center and proving you are in a shortage area. We know there are those shortages.

I have provided for the committee comments on H.R. 2440 provisions. Those reflect the best drafting. I can say with some great humility, I wrote much of what is in S. 556 regarding the Social Security Act provisions and the title IV provisions. They were written conceptually.

I could spend my lifetime and never penetrate to the depths of the Social Security Act and get an amendment quite right. We were blessed with the assistance of Representative Young to have an opportunity to work with House Legislative Counsel who assisted us in turning our concepts into real Social Security Act amendments. We encourage you to look at those and less at the S. 556 provisions.

There is a side-by-side analysis that has been provided to committee members so that you can track from S. 556 to the House bill and understand what is left and how it has been redone. There is also a section-by-section analysis which is attached to my testimony.

I want to mention basically six principles that drive the kinds of amendments. They are first to improve access to Medicare and Medicaid enrollment. It is not, as I mentioned earlier, a natural thought for an Indian elder to seek to apply for Medicare. Many Indian elders are not eligible for Medicare. They are not eligible for Social Security because they did not work in jobs that participate in Social Security during their work years.

But for those who are, it is not natural for them to consider enrolling in part B and using up $700 a year of their limited income to pay part B premiums. Applying for Medicaid is certainly not something they think about even though they may be living in poverty—because they are used to caring for themselves. They expect the Indian health programs to provide the health care they need.

Those programs are not accessible because people resist applying and because in many States services and access by Indian people to the programs operated by the State is not readily available. Some of that is a matter of direct policy by States, of where they locate their services, and some of it is because of the sheer remoteness of where Indian people live in relationship to State services. Finding ways to involve tribes meaningfully in those activities is an important feature of the act so that the rights of Indian people to participate in those programs can be protected.

In addition, reducing co-payments, co-insurance, and deductible obligations without reducing the reimbursement to the tribal or Indian Health Services program also helps to overcome the barrier to access to those programs.

Second, and I have mentioned this before, Indian health programs should enjoy the same kind of special consideration in the Social Security Act provisions that other kinds of health care programs, like federally-qualified health centers, or rural health centers, enjoy. You should not be taken in when somebody says, "Oh, they are trying to create an exception." There are a thousand exceptions.

The Social Security Act provisions on Medicare and Medicaid are basically about two general rules. Everything else is an exception to those rules. We are simply looking for some of the same kinds of things. Nothing we have asked for is fundamentally different than is available for some other kind of provider.

Third, we are looking to minimize administrative barriers. Mr. Rolin spoke to the fact that currently most of the Indian health programs are reimbursed on an encounter per-day rate. We look to maintain that rate while a study of reimbursement is carried out to ensure that any changes in those reimbursement methodologies are carried out in a way that will minimize administrative burdens and will control the costs of trying to build new billing systems, and to respond to the administrative requirements of those programs.

Fourth, we want to encourage cooperation with the States. Medicaid is a partnership with States that cannot be effectively carried out by tribes without a good relationship with the States. We look for additional consultation on their part, and in some other provisions to find ways to improve the relationships.

Among those is to reduce the role of the States in licensing tribal facilities and tribal providers so long as they meet the quality standards imposed by the Social Security Act. It basically would put the tribal providers in the same position that the Federal Indian Health Service providers are, vis-a-vis State regulation. We look to try to achieve that more uniformly.

Finally, we want to improve communication by the formation of a technical assistance group in which people like myself and Mim Dixon, along with health care providers from tribal programs and others can work on behalf of tribal leaders, and in direct interaction with CMS, to work through issues as they arise so that when the Department of Health and Human Services is making policy changes, they do so fully aware of the consequences of them. What happens now all too often is that they make the change and it is only months down the road that the impact of that change becomes apparent and we all scramble to find a way to fix it.

I join with the others in encouraging that this committee keep this bill intact, that it endorse these provisions, and that it work closely with other committees of the Senate and the House who have jurisdiction over certain of these provisions relating to the Social Security Act to ensure that they will give those requests the serious attention that they are due. It is easy to lose small changes. In an environment in which you are trying to make changes as massive as adopting Medicare prescription drugs, the very tiny nature of what we are asking for should not stop serious consideration of them.

Thank you very much. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

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

The CHAIRMAN. Thank you, Ms. Munson.

By the way, do not worry about not getting things right. We work year-around here and if you could read our mail, we never get things right. We just have to keep trying. That is why you never get rid of us, I guess.

Before I go on, I did not know what Senator Murkowski's schedule is, particularly since Ms. Munson is from Juneau.

Do you have any opening statement or comments before we go on? I do not know if you have to leave.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I will be leaving in about 15 minutes, but I did want to hear the testimony of Ms. Munson and welcome her as a constituent. I also want to welcome a former constituent, Ms. Dixon. I am looking forward to her testimony. I understand she is from Fairbanks, as I am. We share a lot there.

I just wanted to listen to the comments this morning and thank you, Mr. Chairman, for continuing on this very important issue of the reauthorization of Indian health.

The CHAIRMAN. Thank you.

Ms. Dixon, please proceed.

STATEMENT OF MIM DIXON, DIXON & ASSOCIATES, BOULDER, CO

Ms. DIXON. Thank you, Chairman Campbell and Senator Murkowski, tribal leaders, and honored guests today.

There has been a lot of talk recently about modernizing Medicare and, in a way, the proposed Title IV of the Indian Health Care Improvement Act, and the proposed amendments to Medicaid, Medicare, and the Social Security Act, could be considering modernizing Indian health care. As we know, this is not an appropriations bill and it will not provide the funding to bring programs and facilities up to standards.

So when I talk about modernizing Indian health care, I am not talking about the delivery of services. Rather I am talking about modernizing the legal and regulatory framework that allows the Indian health programs to bill Medicaid, SCHIP, Medicare, and private insurance, and to be paid for the covered services that are provided to mutual beneficiaries.

Title IV and the Social Security Act amendments are needed to respond to changes that have occurred in health care delivery in our country in the past decade. Just a few years ago there was no Medicaid managed care. There was no SCHIP. There was no Medicare Part C or D or E. In most States, tribes have not been included in the planning for these changes in Medicaid, or to the development of SCHIP programs.

It is difficult for Indian health care to interface with the Medicaid, SCHIP and Medicare of today. Indian health programs are unique in many ways that make it impossible for many Indian health facilities and programs to meet the usual requirements to become providers under managed care programs.

Yet the Indian Health Service beneficiaries who are enrolled in managed care programs under their Medicaid and SCHIP pro-

grams will go off-plan to seek care at their Indian health care facility. It is essential that they have that unrestricted choice and that the Indian health facility can bill and be paid for the services it provides.

Provisions in the Indian Health Care Improvement Act also allow tribes to take advantage of some of the opportunities provided by managed care. For example, they could use funds from the Indian Health Serve as to purchase managed care plans or other insurance programs for their beneficiaries. The measures would also require States to allow Indian health providers to service case managers for American Indian and Alaska Native Medicaid beneficiaries.

Despite the increasing reliance of Indian health programs on third-party collections, many American Indians who are eligible for Medicaid and SCHIP are not enrolled in those programs. To remedy this situation, this bill authorizes funding for tribes for outreach services. The bills would also eliminate financial barriers to enrollment in Medicaid and SCHIP, such as premiums, deductibles, and co-pays.

Many of the issues relating to Indian health care financing are extremely complicated. Tribes have recognized that there is a need for a national Tribal Technical Advisory Group to work closely with CMS to resolve problems as they arise. To operate effectively, this TTAG must be authorized in law. The TTAG will be essential for helping to implement the provisions in Title IV of the Indian Health Care Improvement Act, and for all the proposed changes in Medicare under the proposed prescription drug legislation and proposed Medicaid reform.

In closing, it is important to remember the purpose of this legislation. At the heart of the provisions in title IV is enhancing access to care for American Indians and Alaska Natives, protecting their rights to choose their health care providers, and assuring that Indian health care facilities get paid when they provide services under Medicaid, SCHIP, and Medicare to those beneficiaries.

I have submitted written testimony which provides greater detail on these points. Thank you. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

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

The CHAIRMAN. Thank you, Ms. Dixon.

Let me ask a couple of questions. Let me start with Ms. Benjamin. Thank you for being here.

I have been a big supporter, as you know, for years of self-governance. It seems to me that the tribes, if they have the capability, should be offered that opportunity. In most cases they do a better job than the Federal Government could have done.

But with that in mind, I guess there are some things that probably ought to remain with the Agency. Let me just ask you a couple of things on that. With that thought in mind, what is your view on Secretarial oversight for the tribal direct billing program?

Ms. BENJAMIN. That's a hard question.

The CHAIRMAN. Yes; I know. That is why I asked you. [Laughter.]

Do you think tribes could do that better than can be done through the Agency?

Ms. BENJAMIN. We know what our need is for our membership. I think we can address the health disparity issues better than an outside entity doing that. So I would support that tribes would have that authority to do that.

The CHAIRMAN. Your testimony also includes a concern that tribes are usually not consulted in the design of the State Medicaid programs. It is not unusual, unfortunately. We hear that very often here in the committee that there is a lack of good in-depth consulting with the tribes before decisions are made.

How do we encourage tribal State collaboration in the design of health insurance programs so that they are inclusive of Indian people's needs?

Ms. BENJAMIN. I guess I can look at our example. Currently what we have for our membership is called a "Circle of Health." We provide some health care opportunities for all of our members, regardless of where they live in the United States. There is a process that they have to go through, of course. Our goal is to make sure that people that may not live on the reservation, that live in different States, and do not have access, that we are providing a service to them as well.

The CHAIRMAN. Do you do that through the mail? Do you offer advice, say, of 500 miles away and cannot get home to the clinic?

Ms. BENJAMIN. We send them applications where they would be able to get some insurance in their State. We help pay the premiums for that, to get that done. We want to make sure that our membership is not forgotten, if they live elsewhere beside the reservation.

The CHAIRMAN. That is a great idea. Has that been pretty successful?

Ms. BENJAMIN. It is successful. We still have a lot of folks that still have not utilized that program. We are continuously trying to educate them and the opportunities through our mailings or newsletters. We also make sure that they know what services are available.

Also, what we are doing with the State of Minnesota is that we try to partner in any way we can. Currently we have some discussions with the TANF program to provide services for Indian people in the Minneapolis-St. Paul area. We also feel that we can show more compassion to Indian people, to our own tribal members or whoever, to get them to become more self-sufficient because of our cultural backgrounds. We can relate to some of those issues, we feel, in a better way than the State or county agencies that are out there.

Those are two examples of what we are trying to do. We want to provide a system that we can hopefully improve lives for membership of our own tribe and other Indian people, even though they do not live directly on the reservation.

The CHAIRMAN. You mentioned that your tribe has difficulty collecting third-party reimbursements, and the little you do collect often goes to meeting health care needs of your tribal members. What are the most serious impediments to preventing the tribe from collecting third-party reimbursements?

Ms. BENJAMIN. I would like to refer that question to Samuel Moose, the Commissioner of Health and Human Services because he administers that. Can you assist me, Sam?

Mr. MOOSE. We are always negotiating with the State and through our State liaison some opportunities within the various programs. Some of the difficulties that we run into is that the State delegates some of that authority to the local county agencies where they were negotiating those rates and opportunities. We have had difficulties in the past.

The CHAIRMAN. Do they just refuse to negotiate? Do they drag their feet?

Mr. MOOSE. Yes; they drag their feet. Some of them come to the table. We really do not make any progress with the issues. There is always a history. There is always something that comes up that somehow creates barrier.

The CHAIRMAN. It is called jumping through hoops.

Mr. MOOSE. Yes.

The CHAIRMAN. It is not uncommon, I guess.

Vice Chairman Rolin, you have put a number of years of dedication to improving the health of Indian people. I want to commend you for that. You have been in here a number of times testifying on their behalf. I thank you for that.

On the Federal medical assistance percentage, I understand that the National Steering Committee decided to remove the 100 percent FMAP expansion provision in S. 556 in response to the Administration's concern that it would be too costly; is that correct?

Mr. ROLIN. That is correct.

The CHAIRMAN. What cost estimates were included in that decision?

Mr. ROLIN. Myra might be able to answer that. She has handled that technical portion.

The CHAIRMAN. We call that passing the buck around here, Myra. Go ahead. [Laughter.]

Mr. ROLIN. That has been her area of expertise.

Ms. MUNSON. If Congress would pass the buck, we would have no problems here. [Laughter.]

The CHAIRMAN. Bucks, plural.

Ms. MUNSON. Many, many bucks. The truth is we really do not know. What we do know is that they came up with an estimate of $2.48 billion for the 100 percent FMAP. We believe that that is a substantial over-estimate of increased costs since we believe that States that currently claiming 100 percent FMAP for a wide variety of activities that they believe, and I think correctly, are already authorized as "through the facility."

A significant amount of the FMAP issue arises out of the difference of interpretation of that phrase, "through the facility," with tribal health programs and the States interpreting it to mean not only the things provided in the building, but things which may be referred out that have to be purchased from other providers. They should also be entitled to that 100 percent FMAP. We think that CBO has over-estimated the number, but we do not have the benefit of having any details so we cannot tell you exactly in what ways.

The CHAIRMAN. I see.

Mr. ROLIN. Senator, if I might add, you noted in my testimony also the States support that. They believe this would be a direct support as far as funding for tribes. They have been most supportive in that aspect.

The CHAIRMAN. We often hear that States deny health care to Indian people by saying it is a Federal responsibility. Is the NSC aware of cases where States have refused public health insurance coverage for eligible Indian people because of that concept?

Mr. ROLIN. I do not know of any. Ms. Dixon, are you familiar with any? I am not aware of any. I know my State has not.

The CHAIRMAN. Ms. Dixon.

Ms. DIXON. I think it is a matter of degree. It is not as black and white as that. I think that there is a higher level of cooperation with the State looking for ways to enhance and support the Indian health system when there is 100 percent FMAP and they are not trying to conserve State funds and they realize that the Federal are there.

For those services where there is not 100 percent FMAP, Medicaid directors tend to take the most conservative approach in terms of allowing tribes to carry out their mission with Medicaid funding.

The CHAIRMAN. Okay.

Ms. Munson.

Ms. MUNSON. If I could, Mr. Chairman, I think the denial plays out in one other way. I think any Indian person who gets their application in and manages to fill it out completely will be granted their eligibility if they satisfy all the conditions. The trick is: Will they ever get the application? Will they understand it? Will they get it completed? Will they meet the deadlines for personal interviews or whatever other hoops they may have to jump through to get it considered? Will, in fact, it be returned to them because there is something missing? Will they have had difficulty getting access?

We believe, and there is pretty good demonstrated evidence of this, that even in States that cooperate, Indian people are substantially under-represented in the Medicaid rolls compared to the level of poverty in Indian country. We think there are many barriers; most of them subtle.

The CHAIRMAN. Including educational problems. Sometimes Indian people do not have the educational opportunities and when they have to fill out some of these complicated Federal or State forms, they are already at a disadvantage.

Ms. MUNSON. Absolutely.

The CHAIRMAN. Ms. Dixon, we are dealing with managed care. You hear it all the time here in Congress, as you probably know. It seems to be the new rage. It seems to be the way we are going. But we do get some feedback that one size does not fit all, particularly in the difference between rural America and urban America. But I think also that might apply to the problems that many Indian people face, and that is cultural differences.

What are your recommendations to try to improve the health care system from a culturally-sensitive aspect for Indian people?

Ms. DIXON. That is a really good question. First, let me say that in essence the Indian health system is a culturally-sensitive managed care system. The issue is not so much the cultural sensitivity within the Indian health system, it is forcing Indian people to en-

roll in managed care plans that are operated by the State under Medicaid. And now with the revisions to Medicare that we are talking about, that is a potential there as well. It has not been so much Medicare up to now, as Medicaid.

Then forcing them to enroll in a Medicaid managed care plan for which the Indian Health System is not a provider. Then they are into a health care system that is off the reservation, or outside their communities, where people have little knowledge of the culture, where there are not people who speak the language, where people do not understand the living conditions. Often times facilities are very hard to access because they are far away. They are defaulted to a facility that might require a great deal of transportation to get there. They do not have the vehicles and the transportation.

What we have recommended—and what tribes have been recommending ever since the National Indian Health Board did its study of the nine State Medicaid programs that have gone into managed care, that had a significant Indian population in those States—is that Indian people be exempted from mandatory enrollment, that States keep a carve-out for Indian health that is paid for on a "fee-for-service." We call it "fee- for-service," but it really is not. It is called the "encounter rate" or the "all-inclusive rate." Sometimes it is the "OMB rate" or the "IHS rate." It is not exactly "fee-for-service," but it is not the capitated managed care payment.

Also, Indian people should be allowed to go to their local Indian facility, if that is what they choose. If they choose to use another facility under Medicaid, they should be allowed to do that as well. But they should not be penalized, and the Indian health facility should not be penalized if a Medicaid recipient chooses to use their local tribal or Indian health care facility.

The CHAIRMAN. I agree.

Ms. Benjamin.

Ms. BENJAMIN. I wanted to comment on the cultural sensitive way of how some of our people deal with the providers. Many of our elders' first language would be Ojibwe. There is that communication barrier sometimes with the providers.

What we provide is traditional healers. They then have a comfort level dealing with someone that can speak and understand their language. Our issue with the traditional healers is that they are not recognized. We are not included in the billing process when we use traditional healing for our membership.

The CHAIRMAN. I think some other tribes have had quite a bit success with that, too. I think the Navajos do that, not only with working with the State for health care but such as surgery, for instance. I understand that they have spiritual leaders that understand the traditional healing ways of the Navajos who work with the doctors. I think that is a terrific idea.

I have often wondered if it creates a liability issue or what is sometimes called the unintended consequences of doing something. I wonder if there is something in there that comes around to haunt you later on why you try to do that. But it seems to me it is the only way to go, particularly for traditional people. That comfort level goes up considerably if they know there is a spiritual attachment to healing.

Mr. Rolin.

Mr. ROLIN. Senator, I have just one more comment regarding the FMAP. I noticed in the most recent Senate prescription bill that Native Hawaiian providers were included. However, our providers were left out. Certainly that is a concern we have as well. We wanted to share that with you.

The CHAIRMAN. Thank you for bringing that to my attention. I did not know that. I will make sure that we look into that and find out why.

Mr. ROLIN. Thank you.

The CHAIRMAN. I have no further questions that I will ask today. I will put some in writing to you. We have many members who are not here today. They will be submitting questions in writing, too. We would appreciate your getting those back to us.

Without objection, so ordered.

We will keep the hearing open for 2 weeks for any additional testimony or letters from anyone in the audience or from our panelists.

I thank you for appearing today.

This committee is adjourned.

[Whereupon, at 11:17 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND OF OJIBWE

Chairman Campbell, Vice Chairman Inouye and distinguished members of the Senate Committee on Indian Affairs, my name is Melanie Benjamin and I am the chief executive of the Mille Lacs Band of Ojibwe. The Mille Lacs Band is a federally recognized tribe of 3,570 members located in East Central Minnesota. We operate three clinics in three Mille Lacs Band districts on our reservation and serve a user population of several thousand.

Three topics will be discussed as they relate to Medicaid and Medicare under Title IV of the Indian Health Care Improvement Act: Sovereignty, the Federal trust responsibility and the health disparities that exist between Indians and the rest of the American population. The access to health services under title IV have a direct connection to the health disparities in Indian country and must be addressed by the Congress. Following the general discussion of the three topics under Medicaid and Medicare will be the Mille Lacs Band recommendation of the establishment of a Tribal Leaders Group and Tribal Technical Advisory Group specific to the Centers for Medicare and Medicaid Services and their work with the Indian Health Service [IHS]. The statement concludes with one final issue of concern to the Mille Lacs Band: the Department of Health and Human Services' "One" HHS Initiative.

When the Indian Health Care Improvement Act was first enacted in 1976, Congress recognized its trust responsibility toward the tribes to provide adequate health care. Throughout the subsequent amendments and reauthorizations of the Act, one of the major underlying policies has been to provide tribes access to other Federal health care sources like Medicare and Medicaid programs. These programs have unlimited funding, as opposed to Indian Health Service programs that have funding limits each year. The intent was and is to improve our health status through that access. Since then Medicare and Medicaid reimbursements to tribes, including the Mille Lacs Band, have become a significant source of revenue for our health care programs and operations.

Over the last 15 years, the Mille Lacs Band of Ojibwe has actively participated in the formulation of Tribal Self-Governance policy. We take pride in being one of the first ten Self-Governance tribes. We participated in the original demonstration project and the 1 writing of the permanent Acts for BIA and IHS Self-Governance. The Mille Lacs Band has also been on the rulemaking committees for the implementation of Self-Governance laws. Presently, the Mille Lacs Band of Ojibwe is an active member with the Tribal Self-Governance Advisory Committee that advises Federal agencies on Indian policy matters affecting the Self-Governance tribes.

The Mille Lacs Band has supported and advocated for Self-Governance laws because our philosophy is that we should be free to govern ourselves and develop our own policies in the administration of our tribal programs. To us, this is an important exercise of sovereignty. In that exercise of sovereignty, we should not be entangled by a Federal or State bureaucracy.

There are three principles that the Mille Lacs Band of Ojibwe considers when analyzing Federal programs. First, we assert that our primary relationship is with the Federal Government. This tribal-Federal relationship has been established through treaties with the United States, Executive orders, Federal statutes and numerous court decisions recognizing the same. Second, we retain all sovereignty not expressly taken away, and therefore we should have the ability to control funds reserved for us under Federal law. Third, we should have equal access to the same funding avenues as States. This third principle raises the fundamental flaw of the Medicaid and Medicare programs.

It is the Band's understanding that the design of the Medicaid and Medicare programs is a Federal—State collaboration. The problem is that tribes do not fit into the picture at all and this design flaw makes it very difficult to meet the criteria for receiving reimbursements. An example is that counties receive an administrative match from the state for their administrative costs while tribes cannot. According to the Mille Lacs Band of Ojibwe Commissioner of Health and Human Services, our inability to recover the administrative match demonstrates that tribes do not have equal access to Medicaid and Medicare reimbursements. The reason is that States determine how their block grants will be distributed under their own guidelines. As a result, the Mille Lacs Band and many other tribes lose out on potential and critical avenues of funding we desperately need because Federal funding through the Indian health service. Others on this panel have addressed this and other legal barriers more specifically, but from a tribal leader perspective it is clear that states and managed care systems have predominance over tribes under Medicaid and Medicare.

Clearly, the establishment of the Medicaid and Medicare entitlement programs happened at a time in history when the Congress did not focus on tribal sovereignty. Presently tribes are treated as governments in Federal legislation and tribal sovereignty is recognized. Indian people are provided direct access to Federal programs and funding. The Mille Lacs Band of Ojibwe receives direct funding through our Self-Governance Indian Health Service and Bureau of Indian Affairs Annual Funding Agreements. But when it comes to Medicaid and Medicare programs, it is a different situation. It is time to change the Medicaid and Medicare provisions under Title IV of the Indian Health Care Improvement Act to reflect the new enlightened view of tribal sovereignty and provide tribes more access to health care services as the Act was originally intended.

Through our treaties, Federal statutes, Executive orders and court decisions, a Federal trust responsibility has been established and recognized over the course of dealings with tribes. The Mille Lacs Band of Ojibwe signed several treaties with the United States, and the provision of proper health care became an expectation of the Band and an obligation of the Federal Government. In addition, the Snyder Act of 1921, the Transfer Act of 1954, the Self-Determination Act of 1975, the Indian Health Care Improvement Act of 1976, as well as the enactment of the IHS Self-Governance Act, all evidence the trust obligations that flow to the tribes from the Federal Government for the provision of health care.

In spite of the clear legal duty created by these Federal statutes, the Federal obligation to provide adequate health care to tribes has never been properly funded. Historically, this insufficient funding has interfered with our ability to provide comprehensive health care to Mille Lacs Band members. According to IRS estimates, the Mille Lacs Band and all other tribes in the Bemidji are funded at approximately 30 percent of need. This means more than two-thirds of our need is not being met and explains why the status of Indian health on the Mille Lacs Band Reservation and almost all other tribal reservations is so poor. We are told that the Federal Government spends nearly twice as much for a prisoner's health care than it does for Indians. This fact is an example of why our health status is at the bottom of every disease category.

It seems ironic that Indian health care through the IHS is not an entitlement for Indian people when tribes essentially pre-paid for our health care by ceding millions of acres of land to the Federal Government. It seems even more ironic that tribes have problems accessing the Federal entitlement programs like Medicaid and Medicare which were designed for all state citizens. This funding disparity becomes a matter of fairness and equity because Indian people are also citizens of the States in which we reside. It is only logical that we should have the same access to the same services as do other non-Indian citizens.

Given that we have been historically under funded for our health care needs and that tribes likely will not receive funding for the level of need in the next appropriations cycle, the Federal trust responsibility needs to be taken seriously and changes made to allow tribes full participation in the existing entitlement programs of Medicaid and Medicare. It is fair and it is right.

It has been more than 25 years ago since the Indian Health Care Improvement Act was enacted. The primary purpose of the legislation was to improve the health status of Indians to a level comparable with the general U.S. population. While strides have certainly been made in the delivery of Indian health care in that time, there continue to be health disparities in Indian country that are recited time and time again. The numbers change slightly, but one constant is that Indians rank highest in nearly every category of disease incidence than the general American population. It is plain and simple that Indian health status is not improving and something must be done.

On the Mille Lacs Band Reservation, diabetes is a very serious problem. There is not one family without diabetes among one of their family members. For many of our Band members, it is not a matter of if they get the disease, but when. Band members are losing their vision due to glaucoma complications, they are losing their limbs because of circulatory problems and many are close to requiring kidney dialysis treatments. This chronic disease affects our members' quality of life and it affects the lives of their family members.

More alarming is that diabetes and other long-term chronic health conditions are now occurring in our children and our youth. We have serious concerns for their long-term health and longevity. Our children and youth are our future and we must aggressively confront these health problems to preserve our tribal communities. There are no answers but it is clear that adequate and comprehensive Indian health care is a critical part of the solution.

The ability to provide comprehensive health care on our reservations is paramount because frequently our members will use only our tribal health facilities. The Mille Lacs Band is located in a rural area and other health care facilities are long distances. Our three clinics attempt to provide the health care our members need, but resources are quickly used and we make every effort to access outside funding through Medicaid and Medicare reimbursements within the limitations of existing law. More often than not, our efforts cannot meet our needs. We are fighting to protect the lives and health of our members on our reservations and in our communities. If Congress makes the necessary changes to Title IV of the Indian Health Care Improvement Act and provides more access to Federal health care services and funds, it will at least give us another weapon in this war on health disparities.

Under Executive Order Number 113175, the Tribal Consultation Policy, the Indian Health Service frequently solicits tribal input on health care matters that affect Indian country. The same cannot be said for other agencies within the Federal Department of Health and Human Services. Two examples that demonstrate the lack of tribal consultation are the proposed Medicaid and Medicare Reform that will affect tribal health care programs throughout Indian country.

The Department of Health and Human Services and the Mille Lacs Band of Ojibwe, along with the other federally recognized tribes throughout the United States, share the common goal of providing accessible and culturally-appropriate health care that we believe is best achieved by working together at the earliest stages of policy development and certainly prior to implementation. The Mille Lacs Band of Ojibwe endorses and supports the Secretarial appointment of a Tribal Leaders Group [TLG] that would provide policy guidance throughout the Department of Health and Human Services. The Mille Lacs Band also endorses and supports the Tribal Technical Advisory Group [TTAG] that would provide technical expertise on complicated Indian policy matters and issues specifically to the Centers for Medicare and Medicaid Services.

The Tribal Leaders Group has been sanctioned by the National Indian Health Board, the National Congress of American Indians and the Tribal Self-Governance Advisory Committee, and would be comprised of tribal leadership from each of the Indian Health Service areas. These three organizations are recognized by the Federal Government and the agencies that handle Indian affairs, but on many occasions Indian policy is overlooked by lawmakers and policymakers during the process of policy development. The Tribal Leaders Group would provide important policy recommendations to the Department of Health and Human Services on proposed initiatives that affect health care delivery throughout Indian Country, which in turn furthers the government-to-government relationship that fulfills the objectives of the tribal consultation policy.

On a more specific level, the Tribal Technical Advisory Group [TTAG] would provide the technical expertise and knowledge to the Centers for Medicare and Medicaid Services that is required when dealing with complex issues like Medicaid and Medicare Reform. The TTAG is also sanctioned by the National Indian Health Board, the National Congress of American Indians and the Tribal Self-Governance Advisory Committee. The Centers for Medicare and Medicaid Services has drafted a charter for the TTAG that provides representation from the three national Indian

organizations identified above; however, the Mille Lacs Band and the TTAG believe that the Group should also require the participation of at least three technical advisers that are familiar with health care financing and administration and how proposed changes will affect Indian country.

Through the Secretarial appointment of the Tribal Leaders Group and the Tribal Technical Advisory Group, tribal involvement from the earliest stages of policy development will ensure that Indian issues will be adequately addressed. Involvement and consultation also furthers the government-to-government relationship that the Mille Lacs Band of Ojibwe believes is part of the Federal trust responsibility to tribes.

The Mille Lacs Band of Ojibwe has a number of concerns with the Secretary of the Department of Health and Human Services' One HHS Initiative. First, the Initiative has not involved tribal consultation and that lack of consultation undermines the government-to-government relationship that tribes enjoy with the Federal Government. One of the underlying policies of Executive Order Number 13175 was and is to involve tribes at the policymaking level and work with decisionmakers to enhance the government-to-government relationship. The Mille Lacs Band of Ojibwe and other tribes want to be involved and consulted on health and human service policy matters that affect Indian country because we know best what our tribal communities need and can provide that knowledge to HHS officials.

Second, tribes' unique status as sovereign governments who are federally-recognized political entities is overlooked by the One HHS initiative. As a federally-recognized tribe, the Mille Lacs Band of Ojibwe is a sovereign government that has a government-to-government relationship with the Federal Government and its agencies. Our Self-Governance compacts are an expression of that relationship. As political entities recognized by the Federal Government, the Mille Lacs Band and other tribes cannot be treated as simply another racial minority group. The U.S. Constitution, our Treaties, Presidential Executive orders, and Federal statutes and court decisions all affirm our political status as sovereign governments that are distinctly separate from all other racial and minority groups. By engaging in tribal consultation, Federal agencies will support tribes' government-to-government relationship expressed in the above mentioned instruments.

Third, implementation of the One HHS Initiative is a departmental reorganization that fails to recognize the Indian Health Services' unique responsibility to Indian tribes. The restructuring of the HHS does not acknowledge the unique relationship between the Indian Health Service and the federally-recognized tribes. By incorporating Indian health care into public health and minority health programs, the Indian Health Service may lose its ability to provide direct medical services to tribes and eventually may see the loss of programs designed specifically for tribes. Inherent in the restructuring is an alteration of the Federal trust responsibility. Indian Health Service exists to fulfill the Federal trust responsibility of providing health care to tribes across the United States and attempting to improve the health status in Indian country. Removing that trust responsibility runs counter to the very purpose of the Indian Health Care Improvement Act.

The Mille Lacs Band of Ojibwe recognizes that improvements have been made in the delivery of health and human services since the enactment of the Indian Health Care Improvement Act in 1976. However, we still have significant health disparities in our communities that have not seen improvement. This tells us there must be greater efforts to address Indian health disparities. Those efforts must involve tribal consultation and coordinated discussions for any result to be obtained. It is not too late to engage tribes and begin working together to move forward and improve Indian health disparities.

Miigwech.

PREPARED STATEMENT OF BUFORD ROLIN, VICE CHAIRMAN, POARCH CREEK OF INDIANS

Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Buford Rolin, member at large of the National Indian Health Board. I am an elected official of the Poarch Creek Band of Indians, serving as vice chairman. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on the Reauthorization of the Indian Health Care Improvement Act.

The NIHB serves nearly all federally recognized American Indian and Alaska Native (AI/AN) tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level of health care and the adequacy of funding for health services that are operated by

the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the 12 areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

I would first like to commend the witnesses that testified before me this morning, Mim Dixon and Myra Munson, for their tireless work and expertise on American Indian and Alaska Native issues related to Medicare, Medicaid and the Children's Health Insurance Program. I am also much honored to testify this morning alongside Chief Executive Melanie Benjamin of the Mille Lacs Band of Ojibwe.

Given the two previous hearings the committee has held on the Indian Health Care Improvement Act during the 108th Congress, I'm going to be brief this morning. I realize the members are quite aware of the need and purpose of the reauthorization; therefore I would like to focus on the efforts of tribal leaders to craft legislation that addresses previous concerns raised by the Administration and responds to the current political realities facing Congress.

The National Steering Committee [NSC] was formed by the Indian Health Service in 1999 to develop and submit recommendations for changes to the Indian Health Care Improvement Act. The NSC is comprised of elected tribal representatives throughout Indian country, and also includes urban health program representation. The NSC is currently cochaired by Julia Davis-Wheeler, NIHB Chair, and Rachel Joseph of the Lone Pine Paiute Shoshone Tribe.

Over the last several years, the NSC has worked closely with Indian country, the Administration, Congress, and the Indian Health Service to develop amendments to the Indian Health Care Improvement Act. Indian country has proceeded through this process in a spirit of cooperation and negotiation and the language has gone through several changes.

At the request of Tribal leaders, the Centers for Medicare and Medicaid Services [CMS] established the Tribal Technical Advisory Group (TTAG) to advise CMS on Medicare, Medicaid, and Children's Health Insurance (CHIP) policy issues related to American Indians and Alaska Natives. The TTAG was formed in 2001 and consists of Tribal leaders, Area Indian Health Boards, and designated national Tribal organizations, including the National Indian Health Board. The activities of the TTAG are coordinated primarily through the Intergovernmental and Tribal Affairs Office within CMS.

The TTAG has forwarded several recommendations to Congress and CMS regarding recommended changes to the reimbursement methodologies in place for the Indian Health Service, Tribal health programs, and Urban Indian programs. The TTAG is adamant in its position that any reform or changes in the Medicare, Medicaid, or CHIP programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

The TTAG has worked closely with the National Steering Committee to develop the changes to Title IV of the Indian Health Care Improvement Act that are reflected in H.R. 2440, which are the most recent NSC recommendations.

As the committee is well aware, funding for the Indian Health Service lags far behind other segments of the population and has failed to keep pace with population increases and inflation. Current Indian Health Service funding is so inadequate that less than 60 percent of the health care needs of American Indians and Alaska Natives are being met. In order to address the need for additional health care resources, Title IV of the Indian Health Care Improvement Act addresses access to Medicare, Medicaid and other third party reimbursements. It is one of the most important provisions of the Indian Health Care Improvement Act as it makes IHS hospitals eligible for Medicare reimbursements, and also makes IHS facilities eligible for Medicaid reimbursements. Title IV makes it possible for Medicare and Medicaid eligible American Indians and Alaska Natives to utilize these benefits.

Since the passage of the Health Care Improvement Act in 1976, Medicare and Medicaid payments have become vital sources of revenue for basic tribal hospital and clinic operations. In fiscal year 2002 alone, IHS and tribally operated hospitals and clinics collected $460 million for services provided to Indian people enrolled in these programs. This amount enhances the resources available for the IHS hospitals and health clinics budget by nearly 30 percent.

In order to further improve the ability of Indian Country health providers to access third party resources, the NSC developed several changes to Title IV that were included in S. 212 introduced during the 107th Congress. When asked to respond to the language contained in S. 212, several concerns were raised by Health and Human Services Secretary Tommy G. Thompson regarding the proposed changes to title IV. The concerns were primarily related to costs. I would like to note that S.

556 introduced during this Congress is identical to S. 212 and therefore many of the concerns raised in regards to S. 212 remain.

In response to those concerns, the National Steering Committee revised their recommendations for the reauthorization and those changes are reflected in H.R. 2440, which was introduced on June 11, 2003. I think it was,quite helpful to hold the joint Senate Committee on Indian Affairs and House Resources Committee hearing on the IHCIA last week as it illustrates the efforts of both houses to pass a bill this session. Although the bill was introduced in the House, it was developed with input and involvement from both Senate and House members and staff.

H.R. 2440 reflects several changes made to the original tribal proposal prepared in 1999 by the National Steering Committee (NSC). The legislation includes revisions to the 1999 proposal in response to the Secretary Thompson's concerns. Some of the major changes of the revised Tribal recommendations made ii?- H.R. 2440 that respond to the Administration's concerns about S. 212.

Qualified Indian Health Program [QIHP]. This provision has been removed. The NSC designed QIHP as a new provider type through which Indian health programs and urban Indian health programs could more fully exercise their statutory authority to receive payments under Medicare, Medicaid and SCHIP. Secretary Thompson expressed concern that QIHP was complex and would be administratively burdensome. Tribal leaders acknowledged that the CBO score of this provision—in excess of $3 billion over 10 years—could be a barrier to Congressional acceptance of QIHP and therefore removed it.

In place of the QIHP proposal, Tribal leaders seek a comprehensive study by the Department of Health and Human Services [DHHS] of reimbursement methodologies of Medicare and Medicaid for the Indian Health Service [IHS], Tribal health programs, and health programs of urban Indian organizations. The new provision found in H.R. 2440 directs the Secretary to perform such a study and report the findings to Congress. The Secretary is to examine whether payment amounts under current methodologies are sufficient to assure access to care and whether these methodologies should be revised consistent with those applicable to the "most favored" providers under the Social Security Act. The current "all-inclusive" rate system through which IHS and tribal hospitals and some clinics now receive Medicare and Medicaid reimbursements would remain in place until the Secretary's recommendations are reported to Congress and Congress decides whether to make any changes.

Extension of 100 percent Federal Medical Assistance Percentage [FMAP]. Tribal leaders also agreed to delete a provision that would have extended the 100 percent FMAP to services provided to Medicaid eligible Indians referred by IHS or tribal programs to outside providers, such as referrals made through the contract health services program. Under current interpretation of the Centers for Medicare and Medicaid Services [CMS], the 100 percent FMAP is made available to States only for reimbursements for services provided directly in an IHS or tribal facility, even though the only reason the patient required care outside the IHS or tribal facility was that the facility could not directly provide the service and had to rely on an outside provider.

While State governments are very supportive of the 100 percent FMAP expansion, DHHS objected that its cost was too high—more than $2 billion over 10 years—and that its financial benefits would flow only to the States, not to Indian health programs and their Indian beneficiaries. While the NSC disagrees with the Department's interpretation of the statute and their conclusions about the effect of the proposed amendment, we agreed to delete the provision from the IHCIA.

Waiver of Medicare Late Enrollment Penalty. The 1999 tribal proposal—and S. 212 and S. 556—sought to waive the premium penalty for any Medicare-eligible Indian who did not timely enroll in Medicare Part B because of a number of barriers. The DHHS strongly objected to this provision as it would treat Indians differently than other Medicare-eligible persons who do not timely enroll. The DHHS asserts that the penalty is needed to encourage eligible persons to enroll and begin paying Part B premiums when they first become eligible, rather than waiting until they become ill and need to use their Medicare coverage. Tribal leaders also agreed, reluctantly, to delete this provision.

Regulations. Secretary Thompson objected to the tribal leaders' call for all regulations—including Social Security Act regulations affecting Indian health providers—to be prepared through Negotiated Rulemaking with tribal representatives. He asserted that the large number and complexity of Social Security Act regulations makes negotiated rulemaking unfeasible. In response to this concern, tribal leaders eliminated Social Security Act changes from the bill's negotiated rulemaking provision.

We believe the changes to the original tribal proposal submitted in 1999 significantly reduce the bill's Federal budget impact. S. 212 [identical to S. 556] was scored in 2001 as having a Federal budget impact of $6.9 billion over 10 years. Deletion of the QIHP and the 100 percent FMAP provisions together reduce the bill's score by about 70 percent. We ask that the committee submit a request to the Congressional Budget Office to either score S. 556 without the above mentioned provisions, or provide a fiscal budget impact on H.R. 2440.

Conclusion. On behalf of the National Indian Health Board, I would like to thank the committee for its consideration of my testimony and for your diligence in making the health of American Indian and Alaska Native people a high priority of the 108th Congress. I have been involved with the National Steering Committee since its inception in 1999 and have seen the hard work and compromises that the tribal leaders have made. Tribal leaders have come to the table to work out the more contentious provisions and we urge the committee to act swiftly on this important piece of legislation. Further, we request that any concerns regarding this legislation are raised in a timely manner so that passage of this bill during this session is not jeopardized.

BUFORD ROLIN, MEMBER AT LARGE, NATIONAL INDIAN HEALTH BOARD, RESPONSES TO QUESTIONS

On behalf of the National Indian Health Board [NIHB], a non-profit organization established in 1972 to serve nearly 558 federally recognized tribal governments in advocating for the improvement of health care delivery for American Indians and Alaska Natives, I am pleased to respond to your letter dated August 1, 2003 regarding my recent testimony on S. 556, the Indian Health Care Improvement Act Reauthorization.

No. 1. Federal Medical Assistance Program [FMAP]. There appears to be a concern that a 100-percent FMAP provision is too costly.

Question A—What is the purpose of the 100 percent FMAP and what are the cost estimates used to determine the provision was too costly?

Response. The discussion of the 100 percent FMAP provision, section 212 of S. 556, has become quite complicated. The National Steering Committee [NSC] endorses passage of a provision of law that will clarify the intent of Congress and require full implementation of what we, and many states, believe is existing law. We are hopeful that the 100 percent FMAP provision will compel the Centers for Medicare and Medicaid Services [CMS] to do what we think it should already do.

After the Congressional Budget Office [CBO] issued its score on the provision in S. 212, the predecessor to S. 556, and the Administration expressed its objection to the provision, the NSC reluctantly determined that the provision was likely to hinder efforts to reauthorize the Indian Health Care Improvement Act and therefore agreed to its removal from the bill in favor of free-standing legislation. Current law states: "the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1602 of Title 25)."

42 U.S.C. § 1396 (d) (b) (emphasis added.). The NSC believes that "through" encompasses all services provided directly by the Indian Health Service [IHS] and tribes and tribal organizations operating health programs under the Indian Self-Determination and Education Assistance Act [ISDEAA], as well as non-facility based services—such as home and community-based services—and services that the Indian health program would have paid for from its contract health service program, but for the patient being Medicaid eligible. CMS has generally interpreted "through" to mean "in," applying the 100 percent FMAP only for services provided in an IHS or tribal facility.

Authorization of 100 percent reimbursement for States for services provided through the IHS reflects Congressional understanding that the obligation to provide health care to American Indians and Alaska Natives is a Federal obligation deriving from the Constitution, treaties and laws and paid for by tribes with hundreds of millions of acres of land. Pragmatically, it serves to encourage States to recognize the importance of IHS and tribal providers to ensuring that Indians have access to culturally appropriate and sensitive health care. Please see the response to question B for a more thorough discussion of this latter point.

Unfortunately, the NSC is not privy to the CBO scoring methodology or to information that may have been provided to CBO by CMS. We do believe it is highly probable that the score is inflated substantially. Many States have interpreted the

current law to permit them to claim exactly what is described in § 212 of S. 556. Accordingly, they have been claiming, and until recently, often been being reimbursed, at that level. Thus, the expenditures are not new, but part of the current budget.

Second, we believe it possible that the score includes an estimate of the cost of all services to Indians by non-IHS providers whether there was a referral from the IHS or tribal health program or not. This would significantly inflate the score. The intent of the NSC is only that services provided based on such a referral be included. By limiting it in this way, the continuity of care for Indian patients and the integrity of the Indian health system are retained.

The score was so high that it also makes us wonder if CBO was relying on census numbers for estimating the number of Indians instead of the number of active users in the Indian health system. What is clear to us is that American Indians and Alaska Natives are not receiving the benefit of services in amounts anywhere equivalent to the CBO estimates and that the Indian health system continues to be dramatically underfunded to carry out its mission. Both should be remedied.

Question B—If FMAP is not enacted, is there a chance that some States may not extend services to Indians unless the 100-percent FMAP applies?

Response. The relationship between States and tribes varies dramatically from State to State, administration to administration, issue to issue. It ranges from enmity, to distrust, to indifference with occasional shining lights of cooperation. The hostilities arise typically from historical and present conflicts over control of resources—land, minerals, water, tax base, to name a few. The indifference arises from a view that since there is a direct Federal/tribal government-to-government relationship, the State has no role. This is reinforced by the human tendency to set priorities based on the "out-of-sight out-of-mind" principle under which rural and remote communities suffer, including Indian communities. Increased reimbursement for Medicaid expenditures won't cure all of this, but it would be a substantial help.

After the execution of the 1996 Memorandum of Agreement between the Health Care Financing Administration [HCFA] [now CMS] and IHS, many States demonstrated a significantly higher willingness to work with IHS and tribes to include them in their Medicaid programs as providers and as programs able to assist Medicaid-eligible Indians to exercise their right to participate in the Medicaid program. This did not happen overnight and it continues to require diligence and outreach by IHS and tribes, but gradually it did happen.

We hesitate to say that states will roll back their cooperation if the narrower interpretations by CMS of their right of recovery is not overcome, but in a time when all states are experiencing financial pressures, particularly centered on their Medicaid programs, it is a high risk. It is a risk we do not believe we should have to take.

No. 2. 1996 MOA between IHS and DHHS: The 1996 Memorandum of Agreement between IHS and DHHS established a 100-percent FMAP which applies to certain services provided by IHS and Tribal "638" programs at their facilities.

Question—Does the MOA apply to tribes who provide programs that are not contracted such as long-term care and, if not, should it?

Response. In our view the MOA did not change anything substantive about the coverage. It makes tribal health facilities, health facilities of the IHS, as if there were a lease between IHS and the tribe, in order to avoid the wasteful exercise of IHS actually having to enter into such leases. Whether the MCA extends to long-term care, is really a question about whether the IHS and tribes should offer long-term care health services, and whether tribes have the right to do so, even if not directly funded by IHS to do so. We believe the answer to all these questions is "yes." Tragically, long-term care wasn't a priority of the IHS because Indians did not live long enough to require it. Tragically, long-term care couldn't be a priority because IHS was so short-funded it could not meet acute care demand, let alone expand to long-term care. Tragically, Indians who were reluctant to leave their families and communities to receive long-term care simply had to forego that option because there were few, if any, nursing homes on or near reservations and predominantly Indian communities.

Thankfully, life expectancy is increasing and long-term care doesn't only have to mean nursing home care, although it is still an important component. Indian tribes and tribal organizations are exercising their right to assume responsibility for carrying out programs of the IHS under both Title I (self-determination) and Title V (self-governance) of the ISDEAA and achieving efficiencies and program improvements only imagined by the IHS under which they can exercise authority to set priorities locally and redesign their programs accordingly. Some tribes have even developed the capability of contributing tribal resources to the mix of funding for health services and this has meant expansion of services, including long-term care. When this

occurs, the MOA absolutely should cover tribal long-term care. In our view, the better question would be why it shouldn't cover long-term care.

Most health care expenditures come at the end of life—some of that expense is due to long-term care. Why should Federal financial participation in delivering health services to American Indians and Alaska Natives end just at the point the expense becomes greatest?

No. 3. States Denying Care to Indians. Federal health care to Indians arises from the special relationship with and obligations of the United States. But, as U.S. citizens, Indians also have equal access to other public health programs available to all other U.S. citizens.

Question—Is the National Steering Committee aware of cases where States have refused public health insurance coverage for eligible Indians because of the belief that health care is a "Federal responsibility"?

Response. The National Steering Committee is not aware of a consistent pattern of such refusals however, tribal leaders are aware of individual cases where this has occurred at the application level. Despite the well established Federal responsibility to provide health services to American Indians and Alaska Natives, tribal members are often discriminated against and are denied the opportunity to even apply for other public health programs based on the "Indians receive free health care," misconception. The result is that tribal members often avoid utilizing such resources in order to avoid such discrimination and do not utilize those resources that are available to them.

Another barrier that exists for tribal members in accessing services outside of the HIS, Tribal, and Urban (I/T/U) system is the eligibility application process. The application process is quite lengthy and arduous, which discourages participation. Tribal leaders are aware of these problems and are taking steps to address them, such as working with States to increase participation.

Statement by Mim Dixon[1]
to
Senate Committee on Indian Affairs
Hearing on Reauthorization of the
Indian Health Care Improvement Act

July 23, 2003

Senators, Tribal Leaders, Honored Guests. I thank you for the invitation to offer my observations about Title IV of the Indian Health Care Improvement Act currently proposed for reauthorization.

It has been my privilege to serve tribes as a health care administrator, researcher and policy analyst for more than 30 years. I have seen many changes during this time, including the emergence of tribally-operated health care delivery systems. At the same time, the private and public insurance programs in our country have changed from predominantly fee-for-service to managed care.

There is a lot of talk recently about "modernizing Medicare." In a way, the proposed Title IV of the Indian Health Care Improvement Act and the proposed amendments to Medicare and Medicaid could be considered "modernizing Indian health care." As we know, this is not an appropriations bill and it will not provide the funding to bring programs and facilities up to the standards that would truly modernize Indian health care. It is interesting to me that the Federal Employee Benefit Package has been cited by the Bush Administration as a benchmark for Medicaid and Medicare reform. As you know, Indian Health Service has conducted a comparison of Indian health funding and the Federal Employee Benefit Package which shows that Congressional funding for IHS is only 52 percent of the level of need.[2] While S. 556 includes attempts in Title IV to address the huge funding gap that has resulted in health disparities among American Indians and Alaska Natives, most of those provisions have been stripped out of H.R.2440, thereby reducing the cost of Title IV by 70 percent.

So, when I talk about "modernizing Indian health care," I am not talking about the delivery of services. Rather, I am talking about modernizing the legal and regulatory framework that allows the Indian health programs to bill Medicaid, SCHIP, Medicare and private insurance and to be paid for the covered services that are provided to their mutual beneficiaries. Title IV and the technical amendments to the Social Security Act codify some administrative decisions that are already in effect and make changes in the law to allow the IHS and tribes to operate in a manner that creates a rational interface with Third Party Payers.

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[1] Mim Dixon, Ph.D., is a consultant with Mim Dixon & Associates, 1618 Spruce Street, Boulder, CO 80302.
[2] FY 2003 IHCIF – Area Summary. Posted on the website www.ihs.gov. March 28, 2003.

To better understand why I call Title IV "modernizing Indian health care," consider some of the changes that have happened in the past 25 years.

Many of you have been involved in Indian health policy longer than I have. And you will remember that the Indian health system was not permitted to bill Medicaid or Medicare until 1976 when the first Indian Health Care Improvement Act amended the Social Security Act, to create section 1880 (Medicare) and section 1911 (Medicaid). It took a long time for the Indian Health Service and tribes to figure out how to bill third parties.

This effort was frustrated by the development of IHS computer software for patient care management that did not even have a billing component. The persistent underfunding of the Indian Health Service has resulted in prioritizing services, such that the acquisition of computer software for billing purposes has necessarily been a low priority. So, third party revenues grew very slowly at first.

The growth in Medicaid and Medicare collections in Indian health facilities has paralleled the growth in tribal contracting and compacting. A survey of tribes in 1998 found that one of the first things tribes did when they starting operating their own health care delivery systems was to develop billing systems to increase their revenues.[3] Between 1993 and 1997, the third party income to the IHS increased by 80 percent.[4] A significant factor in the growth of Medicaid income was the 1996 agreement between the IHS and the Health Care Financing Administration (now called Centers for Medicaid and Medicare Services) that changed the payment policies for tribally-owned and operated facilities to enable them to receive Medicaid payments at the IHS "all-inclusive" rate, and provided a 100 percent Federal Medicaid Assistance Percentage (FMAP) for services provided in those facilities.[5]

Just about the time that the Indian health facilities figured out how to collect Medicaid and Medicare for beneficiaries who used Indian health services, the whole system changed. Medicaid began to emulate the changes in the private insurance industry, shifting to managed care. In most states, tribes were not included in the planning for changes in the Medicaid program, or the development of the SCHIP programs.[6] It was only six years ago, in 1997, that the Kaiser Family Foundation funded NIHB to do a series of case studies of

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[3] Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith CM. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Vol 4.* Denver, CO: National Indian Health Board. 1998.

[4] Mather D. Chapter 4: IHS Financial Trends during Self-governance (Title III) Compacting, FY 93 to F 97. In: Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith CM. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Vol 4.* Denver, CO: National Indian Health Board. 1998.

[5] Indian Health Service and the Health Care Financing Administration. Memorandum of Agreement (MOA) signed December 19, 1996.

[6] Dixon M. *Indian Health in Nine State Medicaid Managed Care Programs.* Denver, CO: National Indian Health Board. 1998b.

managed care in Indian communities.[7] At that time, tribes and the IHS were trying to figure out what managed care was and how they fit into this new system of organizing and paying for health care.

It is difficult for Indian health care to interface with the Medicaid, SCHIP and Medicare of today. Indian health programs are unique in many ways, including tribal sovereignty, the federal trust responsibility and the government-to-government relationship that has existed since before the U.S. Constitution was written and has a long tradition in federal law.[8] Indian health program are also unique because they embody certain legally-established attributes that are expressly prohibited in other government-funded health programs, such as Indian preference in hiring and restricting services to enrolled members of federally-recognized tribes. Perhaps most unique is a health care delivery system so underfunded that it would not be able to stay in business in the private sector, that rations health care according to a priority system, and that does not include the cost of facilities in its rate structure for billing for services.

All of these attributes make it impossible for many Indian health facilities and programs to meet the usual requirements to serve as contracted providers for managed care programs under Medicaid, SCHIP and Medicare programs. In addition, many Indian health facilities cannot meet requirements such as having physicians on-call 24-hours per day, and having modern facilities that meet safety and accessibility codes. Furthermore, Indian health programs usually cannot take the risk involved in managed care contracts.

Despite all the short-comings of the Indian health programs, American Indian and Alaska Native people usually prefer to use them.[9] These programs are more accessible for AI/AN communities and offer care that is more responsive to cultural needs. Furthermore, these programs provide much needed employment for AI/AN communities. AI/AN beneficiaries who are enrolled in managed care plans under Medicaid or SCHIP will go off plan to seek care at their Indian health care facility. It is essential that they have that unrestricted choice and that the Indian health facility can bill and be paid for the services they provide. These policies are included in the IHCIA (section 406 of S. 556, Section 403 of H.R. 2440).

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[7] Dixon M. *Managed Care in American Indian and Alaska Native Communities.* Washington, D.C: American Public Health Association. 1998b.

[8] Shelton, Brett Lee. Chapter 1: Legal and Historical Basis of Indian Health Care in *Public Health Policy for American Indians and Alaska Natives in the 21st Century,* Mim Dixon and Yvette Roubideaux (eds). Washington, DC: American Public Health Association. 2000.

[9] Dixon M, Lasky PS, Iron PE, Marquez C. Factors Affecting Native American Consumer Choice of Health Care Provider Organizations. In: *A Forum on the Implication of Changes in the Health Care Environment for Native American Health.* Washington, DC: The Henry J. Kaiser Family Foundation. 1997.

In 1998, the National Indian Health Board conducted a study of managed care in nine state Medicaid programs.[10] NIHB held a national meeting where recommendations were adopted by the tribes. These recommendations attempted to respond to the growing managed care environment to assure that American Indian and Alaska Native people would have access to culturally competent care through their tribal, urban and IHS clinics. In 2001 there was a follow-up study with ten state Medicaid programs.[11] It showed that the CMS had implemented some of the recommendations from the previous study. Many of the recommendations from both studies are included in the Senate and House bills.

Despite the increasing reliance of Indian health programs on Medicaid and other third party collections, many American Indians who are eligible for Medicaid and SCHIP are not enrolled in the program.[12] The proposed IHCIA reauthorization bills attempt to remedy this situation by authorizing funding for tribes for outreach services, including education regarding eligibility and benefits, translation services, and transportation to offices of eligibility workers (section 404 of S. 556, and section 402 of H.R. 2440).

The bills would also eliminate financial barriers to enrollment, such as premiums, deductibles and co-pays (section 419 of S. 556, and Section 412 of H.R. 2440). These provisions are extremely important because most AI/AN have no incentive to pay for additional health coverage when the Indian health services are provided to them with no out-of-pocket payments. The prohibition against the states charging AI/AN premiums and co-pays is already in place administrative for SCHIP, but it is important to codify this and make it consistent across Medicaid programs as well. It is troubling that the Medicare program deducts 20 percent from its already low payments to Indian health programs for the amount that the Medicare beneficiary is supposed to pay, despite the fact that Indian health programs are prohibited from collecting this amount from consumers. The proposed IHCIA does not address this problem for Medicare, but it does protect against this practice in Medicaid and SCHIP.

In the past five years, tribes have begun to work more closely with states and with the federal government to resolve issues related to Medicaid, SCHIP and Medicare. Putting these provisions into law will clarify areas of ambiguity, resolve problems that can only be resolved through changes in the law. It will

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[10] Dixon M. *Indian Health in Nine State Medicaid Managed Care Programs.* Denver, CO: National Indian Health Board. 1998.

[11] Kauffman JA, Hansen P, Paternoster V. Into the Future: Indian Health, Medicaid, Managed Care & SCHIP, a Ten State Medicaid, Managed Care and SCHIP Program Study. National Indian Health Board. Draft Report, December 20, 2001.

[12] Rosenbaum S. Medicaid and Indian Populations: Issues and Challenges. In: *A Forum on the Implications of Changes in the Health Care Environment for Native American Health Care.* Washington, DC: The Henry J. Kaiser Family Foundation. 1997.

"modernize" the law regarding third party collections for Indian health facilities by addressing issues that didn't even exist until the past decade.

Provisions in the proposed IHCIA Act also allow tribes to take advantage of some of the opportunities provided by managed care. For example, tribes, tribal organizations and urban Indian programs could use their funding from IHS to purchase managed care plans or other insurance coverage for their beneficiaries (Sec 408 of S. 556 and Sec. 405 of H.R. 2440). This may be particularly useful for small tribes that would not have enough resources to offer comprehensive health services on their own. It also may help to stimulate tribes and tribal organizations to own and operate health care plans. Furthermore, the bills would protect tribal sovereignty while promoting quality care, by eliminating any requirements that tribal health programs be licensed under state or local law if they meet accreditation standards recognized by the Secretary of DHHS (Section 411 of S. 556, section 408 of H.R. 2440). The measures would also require states to allow Indian health providers to serve as case managers for AI/AN Medicaid beneficiaries (section 423 of S. 556, section 413 of H.R. 2440).

Many of the issues relating to health care financing are extremely complicated. There are a handful of technical experts working for tribes as health directors, consultants and attorneys. Tribes have recognized that there is a need for these technical experts to work closely with CMS to resolve problems as they arise. NIHB, NCAI and TSGAC have called for a Tribal Technical Advisory Group (TTAG) for CMS. They have designated individuals to serve on an interim TTAG until such time as CMS can establish a formal TTAG. Once again, there is a disconnect between the unique role of tribes and the regulatory framework for advisory committees. To operate effectively, the TTAG must be authorized in law, as proposed in section 409 of H.R.2440 (which was revised and improved after section 425 of S. 556 was drafted). The need for this TTAG is urgent. The interim TTAG has already identified 65 issues that need resolution with CMS, and the TTAG will be essential to helping CMS write regulations for the proposed Medicare reform, proposed Medicaid reform, and the new provisions in the IHCIA.

In summary, Title IV and the Social Security Act amendments are needed to respond to changes that have occurred in health care delivery in our country in the past decade. Just a few years ago, there was no Medicaid managed care, there was no SCHIP, there was no Medicare Part C or D or E. The complexities of health care financing can be overwhelming. So, it is important to remember the purpose of this legislation. At the heart of the provisions in Title IV is enhancing access to care for American Indians and Alaska Natives, protecting their rights to choose their health care providers, and assuring that Indian health facilities get paid when they provide covered services to Medicaid, SCHIP and Medicare beneficiaries.

Testimony of

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Before the Senate Committe on Indian Affairs
Regarding the Reauthorization of the Indian Health Care Improvement Act
H.R. 2440 and S. 556
Title IV and Amendments to the Social Security Act
July 23, 2003

Chairman Campbell, members of the Committee, thank you for the opportunity to testify regarding the reauthorization of the Indian Health Care Improvement Act (IHCIA). The last time I had the privilege of testifying before this Committee was in the late 1980s when I was serving as Commissioner of the Department of Health and Social Services for the State of Alaska. In 1990 I left that post and since have had the honor of representing tribes and tribal organizations as a member of the Sonosky, Chambers Law Firm.

Since the formation of the National Steering Committee (NSC) I have worked with its members, on behalf of the Alaska Native Health Board (ANHB) and the Alaska Native Tribal Health Consortium (ANTHC), to develop and advocate for the reauthorization of the Indian Health Care Improvement Act. Although I have worked on all parts of the bill, due to my experience with Medicaid, Medicare and other third-party recovery, I worked most closely with the members of the National Steering Committee whose task it was to examine the provisions of the Act relating to access to health services – a euphemism for provisions related to financing.

Throughout its work on the Indian Health Care Improvement Act, the National Steering Committee recognized that the IHCIA addresses authorization, not appropriations. The IHCIA, in other words, provides the opportunity, but not necessarily the means. Title IV and the two amendments to the Social Security Act, sections 4 and 5 of H.R. 2440 and Title II of S. 556, are the exception. They actually address mechanisms by which the Indian Health Service (IHS), tribal health programs, and urban Indian organizations can receive reimbursement for the services they provide and thereby reduce the chronic underfunding for Indian health services.

Background

In 1976 during the first authorization of the Indian Health Care Improvement Act, Congress authorized the Indian Health Service and tribal health programs operating through IHS facilities to bill Medicaid and Medicare. This was controversial then and is still. The United States owes a duty to American Indians and Alaska Natives to provide them with health care. Until 1976 that duty had been carried out, however inadequately, through direct appropriations. Since then, some part of each year's budget for the Indian Health Service and for tribal health programs has been assumed by Congress to be available from third-party revenues generated by billing Medicaid, Medicare, and other third-party insurance.

This was not a choice embraced easily by tribes. For many, it appears as an abrogation of the duty by the United States to provide health care, or at least a step in that direction. Many American Indians and Alaska Natives resented being required to apply for Medicaid, a needs-based program equated with welfare. They found it humiliating to have to reveal private information about themselves in order to have access to services to which they they had been promised access. This view is one held especially by the elders, who also fear that reliance on Medicaid will result in the loss of trust assets that would otherwise be passed down to their children.

Tribes and the Indian Health Service have worked hard to overcome these concerns. Pragmatically, there was simply no other choice. Appropriations fail even to keep up with the inflation, let alone begin to close the gap between need and the resources to respond even in part to that need. Third-party revenue simply had to become part of the mix of funding.

To begin to achieve the targets set by the Congress in its budget for the Indian Health Service, the IHS and tribal health programs were compelled to divert resources from other activities to develop billing and coding expertise and systems. As other testimony being provided to you today describes, developing the capacity to carry out this Congressional mandate has been difficult. The information system principally relied upon by IHS, and inherited by tribal health programs as they assumed responsibility under the Indian Self-Determination and Education Assistance Act, is ill-suited for billing. Efforts to develop new software for billing as an add-on or to find software that was compatible has consumed thousands of hours and millions of dollars.

Nor, has the task been made easier by the entities from whom reimbursements are due. Private insurance companies who have been obliged to reimburse IHS and tribal health programs have resisted. Although they collected premiums for the provision of insurance, the fundamental principle underlying most insurance is that it pays only when the covered individual has a personal duty to pay, but for the insurance. Since American Indians and Alaska Natives do not have such a duty when they receive care from an Indian health program, many insurers simply would not believe that the law meant what it said. Both the IHS and tribes have had to resort to litigation to overcome the resistence from private insurers. Although that litigation has been successful, skirmishes occur regularly.

Medicare and Medicaid have posed different, but equal challenges.[1/]

Medicare. Medicare is a national health insurance program for the elderly and disabled. Individuals over 65 years of age are automatically entitled to Medicare Part A if they (or their spouse) are eligible for Social Security payments. A relatively small percentage of Indians enjoy eligibility for Medicare since many elders lacked opportunities to work at jobs that contributed to Social Security. As the life span grows for Indians and more participate in the workforce, the

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1/ I am indebted in the following descriptions of Medicare and Medicaid to the work of the Kaiser Family Foundation for its remarkable work in translating complex Social Security Act programs into English and thereby making them more accessible. *See* MEDICARE FACT SHEET, MEDICARE AT A GLANCE, April 2003, and THE MEDICAID PROGRAM AT A GLANCE, February 2003, published by the Kaiser Family Foundation, and available, along with many other documents, at its website: www.kff.org.

numbers of Indians who are eligible for Medicare will increase.

Medicare Part A pays for inpatient hospital and skilled nursing facility services, home health visits following a hospital or skilled nursing facility stay, and hospice. Medicare Part B is available only to those Medicare eligibles who enroll and pay a monthly premium of $58.70 or $740 annually in 2003. Few elders who have access to an Indian Health program enroll for this benefit since they correctly believe they should be entitled to free health care. For the poorest elders, Medicaid may pay the premiums. Medicare Part B reimburses providers for outpatient hospital services, physician services, laboratory costs, durable medical equipment, and other services. All Medicare payments are subject to deductibles, copayments, and various limitations on the amount of service for which it will pay.

Currently, IHS and tribal facilities may recover only for services provided by hospitals and skilled nursing facilities and, in the past two years, for a limited number of outpatient services reimbursed under Part B. Medicare payments for inpatient hospital services are based on diagnosis; for outpatient hospital services most providers will be required to bill according to a new and complex classification system that is part of the implementation of the outpatient prospective payment system adopted by Medicare. Other services are generally reimbursed on the basis of fee schedules or cost reporting data. The exceptions to the general rules are many, however. There are special reimbursement standards for federally qualified health centers, critical access hospitals. disproportionate share hospitals, certain cancer treatment hospitals, certain children's hospitals, and, at least for now, IHS hospitals (whether operated by IHS or a tribe.)

Reimbursements to IHS and tribal hospitals for outpatient services have been based on a per day rate sometimes referred to as the "encounter rate," "the OMB rate," or the "all-inclusive rate." It is a per day amount for all outpatient services provided on that day. It is negotiated annually between IHS and the Centers for Medicare and Medicaid Services (CMS) based on cost reports submitted by a number of IHS and tribal hospitals. (All payments are less the 20 percent copayment even though the Indian beneficiary is not obliged to pay the copayment.)

This simplified billing method has made recovery possible for facilities that have lacked the capacity to do full individual cost reports and for whom satisfying the requirements of the new outpatient prospective payment system regulations would have been virtually impossible and would have diverted millions of dollars away from other services into new information systems necessary to comply with the complexities of that system.

IHS and tribal clinics not closely connected to an IHS hospital have largely been without any Medicare reimbursement. The newly authorized recovery for Part B services helps a little, but as noted above there are a relatively small number of Indian enrollees. In addition, the recovery for professional services is very low relative to the cost of providing the services and no reimbursement for the cost associated with the facility are included. A few overcome this problem by enrolling as federally qualified health centers, but for many the cost of compliance with the cost reporting requirements, combined with the reality that actual cost is never paid,

Medicaid. Medicaid is the principal public health insurance program for poor Americans. It is a state/federal partnership in which both contribute financially in varying amounts. Federal participation imposes certain limitations on states about who must be served, principally children and their parents living below a certain poverty level; the services that must be covered; and the practitioners who must be allowed to provide certain services. Beyond these minimums, states have great, although not unlimited, flexibility in adding additional populations to be served, services that are covered, and practitioners whose work may be compensated. States are largely responsible for setting their own reimbursement methodologies, again subject to certain constraints. Thus, there are effectively 50 nearly unique Medicaid programs.

When the IHS, tribal health programs and urban Indian organizations participate in Medicaid, they do so largely under the unique conditions imposed by each state as it develops its own program, Thus, the scope of the activity that each program may be reimbursed for and how it will be reimbursed varies dramatically from one state to another. This creates significant challenges for IHS and those tribes that operate health programs in more than one state.

In fiscal year 1997, IHS and tribally operated facilities were projected to receive $184.3 million in Medicaid reimbursements.[2/] This was about 10 percent of the $1.8 billion appropriated for IHS health care services. *Id.* It was only .07 percent of the $258 billion in combined federal and state expenditures in fiscal year 2002.

Medicaid is an especially important program for Indians because of their disproportionate poverty and for Americans generally. Due to the limitations in Medicare, it is the only source of payment for prescription drugs and for long term care for most elders in America. Since the advent of welfare reform, it is increasingly disconnected from other public assistance programs with some children being eligible up to 200 percent of the poverty level.

Although the way states reimburse IHS and tribal health programs varies widely, for most hospital and clinic based services reimbursement is made on the basis of the simplified encounter rates described above. Again these rates assure that some of the cost of the facility are covered and they minimize the complexities of billing and preparing cost reports. For these facility-based services states are reimbursed 100 percent by CMS. The fact that states can count on this level of reimbursement has generated much more positive working relationships between IHS and tribal health programs and the states than generally exist over other issues. While the financial incentive is not a uniform guarantee of cooperation, it is generally effective and has led to significantly more cooperation, especially in states with many tribes and relatively large numbers of Indians.

2/ "Native Americans and Medicaid: Coverage and Financing Issues," Andy Schneider and JoAnn Martinez, the Center on Budget and Policy Priorities for the Kaiser Commission of the Future of Medicaid, December 1997, p. 2.

The Need for Further Change.

The Indian Health Service and tribal health programs reliance on third-party revenues has grown substantially, as direct appropriations have failed to keep up. For some tribal health programs, more than half of the budget for delivery of health care now must be generated through third-party revenues. This poses huge challenges and new risks. The proposed amendments to the IHCIA address these, as well as eliminating barriers that are currently found in the program.

As the National Steering Committee undertook to consider changes needed to the provisions of the Act relating to access, it had to consider many factors. It helps to understand how relatively constrained its requests are, if one considers the following:

- The United States owes a duty to American Indians and Alaska Natives to provide them with health care. As Senator Inouye has often commented, Indians have the first pre-paid health plan in the United States – paid for with their lands and resources.

- Congress determined that its obligations to provide this health care could best be met by a combination of direct appropriations and authorizations for IHS and tribal health programs to be reimbursed for the health services they provide. Resources that are not needed to manage direct appropriations have been and continue to be devoted to pursuing these reimbursements.

- The total funds available for direct delivery of health services from direct appropriations and third-party recovery still provides on a per capita basis not much more than half of the per capita amount spent by the Federal Employee Health Benefit Plan for a much healthier population. There is no point in the foreseeable future when the combination of funds will come close to meeting the need for health care of American Indians and Alaska Natives.

- Since the 1970s when recovery from Medicare and Medicaid were first authorized, there has been a revolution in health care delivery; one that moved patients out of inpatient facilities and instead relies on outpatient services, ambulatory surgeries, and home- and community-based services. The "facility" based model of recovery initially authorized fails to provide adequately for changes in delivery that have occurred.

- American Indians and Alaska Natives "continue to suffer the highest rates of unemployment and poverty;" 31.2 % live in poverty. The unemployment rate is nearly 50% while the national average is 5.8%. Health status continues to be poor and is most striking with regard to diabetes, tuberculosis, alcoholism and fetal alcohol syndrome.[3/]

3/ Letter from the Chairman and Vice-Chairman of the Senate Committee on Indian Affairs to the Chairman and Ranking Member of the Committee on the Budget, United States Senate, March 11, 2003.

- Improving life expectancy will increase health care costs as the population ages.

Another consideration also guided the thinking of the NSC. Both Medicare and Medicaid are riddled with special provider types (federally qualified health centers, rural health centers, critical access hospitals, disproportionate share hospitals, teaching hospitals, to name just a few) and for each there are special reimbursement rules. These special rules are designed to assure that a certain population will have access to care or that a certain objective of the program will be achieved. The NSC seeks only to assure that similar consideration is given to ensuring that these federally funded health insurance programs treat Indian programs similarly – by ensuring that the special conditions under which they operate are taken into account.

Having been compelled to invest in the means to participate in Medicare and Medicaid, tribes simply want to assure that the investment gives them full access to the benefits of the programs, not merely cut-outs designed nearly three decades ago.

Achieving the objectives of full participation in Medicare and Medicaid is no easy task. As the background discussion demonstrates, the programs are complex. They are outside the ordinary experience of tribal leaders and the jurisdiction of those committees of Congress with whom tribal leaders most often work. The National Steering Committee did not allow those factors to be a barrier to putting together a restrained package of proposed improvements. Neither should the Congress allow the relative insignificance of the program changes (when compared to massive changes like the addition of a Medicare Prescription Drug benefit currently being considered in conference, to be an excuse to not consider the proposals. While truly not even a "rounding error" in either the Medicaid or Medicare budget, the fiscal and programmatic impact for Indian health programs can be profound.

Conclusion

A section-by-section analysis of the changes found in H.R. 2440 and the differences between it and S. 556 is attached as an addendum. The analysis is accompanied by brief commentary. I hope it will help explain the purpose of each proposed amendment to the current law. I also hope it will dispel the impression that huge changes are being sought. In fact, the true change could occur only if the funds necessary to keep the commitments of the United States to provide health care to American Indians and Alaska Natives were made available.

In the meantime, swift action to improve access to care by American Indians and Alaska Natives to health programs operated by the Indian Health Service, tribes, and urban Indian organizations by making increased access to federally funded health insurance plans is the next best thing.

Thank you for your consideration. I will be glad to try to respond to your questions, and, if I can't to find someone who can.

Section-by-Section Analysis of Title IV and Amendments to Medicare & Medicaid in H.R. 2440 and S. 556, Reauthorizations of the Indian Health Care Improvement Act[1/]

The 1999 National Steering Committee (NSC) Draft was incorporated almost without change into S. 556, a bill to reauthorize the Indian Health Care Improvement Act (IHCIA). In the three years that have passed since the NSC did its initial work, the NSC has taken the opportunity to respond to concerns expressed by the Department of Health and Human Services (HHS) regarding S. 212, which was the predecessor to S. 556, and, under the director of Representative Don Young, the prime sponsor of H.R. 2440, to work with the House Office of Legislative Counsel to clarify the NSC intent and improve the drafting. All of these changes are incorporated into H.R. 2440.

The NSC has endorsed a request that the Senate substitute Title IV, Access to Health Services, and Sections 4 and 5 of H.R. 2440 for the parallel provisions of S. 556. Accordingly, this section by section analysis addresses principally H.R. 2440 with only occasional comments about the corresponding sections in S. 556. The reasons for not including certain provisions of S. 556 in H.R. 2440 are discussed in somewhat more detail.[2/]

Title IV. Access to Health Services.

Sec. 401. Treatment of Payments under Social Security Act Health Care Programs. This section consolidates multiple sections regarding Medicare and Medicaid into a single simplified provision.

Subsection (a), Disregard of Medicare, Medicaid, and SCHIP Payments in Determining Appropriations, continues the prohibition against consideration of Medicare, Medicaid and SCHIP funds in determining appropriations for the provision of health care and services to Indians.

Subsection (b), Nonpreferential Treatment, continues the requirement that no preference be given to an Indian with Medicare, Medicaid, or SCHIP over an Indian with no such coverage.

Subsection (c), Use of Funds, continues the "special fund" maintained by IHS for receipt of payments from Medicare, Medicaid, and SCHIP to IHS and tribal health programs that have not opted to receive payments directly. It adds a requirement that 100 percent of the receipts must be returned to the Service Unit from which the funds were generated. It maintains the requirement that the funds be used first to maintain the standards applicable to conditions for receipt of such funds imposed under the Social Security Act and provides that any other receipts be used in consultation with the tribes being served to reduce health resources deficiencies.

1/ This section-by-section analysis was drafted initially as an addendum to testimony provided by Myra M. Munson to the Senate Committee on Indian Affairs on July 23, 2003.

2/ A side-by-side comparison of the two bills and the 1999 NSC Draft accompanied with some limited notes has been provided to Committee staff to assist in the ease of comparing these different versions.

Subsection (d), Direct Billing, continues the authorization for tribal health programs to directly bill and receive payments from Medicare, Medicaid, and SCHIP. S. 556 differs from the initial NSC Draft in that it imposes the conditions initially approved by the Congress when it made the Direct Billing Demonstration permanent and extended the authority to other tribal health programs. These include obtaining approval from IHS and submitting reports. H.R. 2440 eliminates these requirements. It makes the payments subject to auditing requirements imposed on tribal health programs and requires that the receipts be used to satisfy conditions of participation, then for improvements in health care facilities and tribal health programs, other health care-related purposes, and otherwise to achieve the objectives provided in section 3 of the Act.

> ***Commentary.*** *IHS informally has expressed reservations about eliminating its role in approving the tribal decision to directly bill and receive funds, although they acknowledge that they have never rejected an application. The elimination of the extra requirements is justified by the experience demonstrated by tribes both during the demonstration and since. To continue them merely continues bureaucratic oversight that has not demonstrated any positive outcome for the program.*

Sec. 402. Grants to and Funding Agreements with the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

Subsections (a), Indian Tribes and Tribal Organizations, and (b), Conditions, continue the authorization for grants to assist Indians to enroll for benefits under Medicare, Medicaid, and adds SCHIP and authorizes payment of premiums, based on financial need as determined by the tribe or tribes being served.

Subsection (c), Agreements Relating to Improving Enrollment of Indians under Social Security Act Programs, continues authority for the Secretary of HHS to enter into agreements under which tribal health programs may receive and process applications for Medicare, Medicaid, and SCHIP. New language also allows the Secretary to enter into such agreements with urban Indian organizations and allows all the agreements to provide for reimbursement of outreach and enrollment efforts. New provisions also allow States to enter into such agreements with tribes and tribal organizations, including reimbursement of costs. This section also protects current arrangements between States and tribes occurring under the Medicaid program. These arrangements are generally referred to as Medicaid administrative match agreements.

Subsection (d), Facilitating Cooperation, provides the Secretary with the duty to facilitate agreements under (c).

Subsection (e), Application to Urban Indian Organizations, permits grants under (a) to be awarded to urban Indian organizations.

> ***Commentary.*** *The high rate of poverty among Indians is not reflected by their participation in Medicare, Medicaid, and SCHIP. Expansion of the role of tribes, tribal organizations and urban Indian organizations is expected to improve access.*

Sec. 403. Reimbursement from Certain Third Parties of Costs of Health Services.

Subsection (a), Right of Recovery, continues to provide a right of recovery by the IHS, tribal health programs, and now urban Indian organizations, from all insurers. It clarifies existing law regarding the amount third parties must pay and extends the duty explicitly to health maintenance organizations, employee benefit plans, third-party tortfeasors and any other responsible or liable third party.

Subsection (b), Limitations on Recoveries from States, continues to limit the right of recovery against a State unless the services were covered under workers' compensation laws or no-fault automobile accident insurance plan or program.

Subsection (c), Nonapplication of Other Laws, limits the effect of State and local laws on the right of recovery.

Subsection (d), No Effect on Private Rights of Action, continues the assurance that the right of recovery provided for above does not interfere with any rights of the individual patient.

Subsection (e), Enforcement, provides for the means of enforcement and modifies the notice requirement to the patient to require that reasonable efforts be made in the event litigation is required.

Subsection (f), Limitation, amends the limitation against IHS billing a tribe's self-insurance plan by permitting such billing if the tribe has authorized it. S. 556 prohibits not only IHS from such billing, but also tribes that have taken over a program from the IHS under the Indian Self-Determination and Education Assistance Act.

> ***Commentary.*** *The NSC opposes the change made in S. 556. It could substantially negatively affect the revenue stream of tribal health programs without providing for any replacement funds. While there is justification for a limitation on billing by IHS of a tribal self-insurance plan when IHS directly operates the health program, extending the limitation to tribally operated health programs interferes with the tribe's exercise of self-determination and has the potential to diminish access to care.*

Subsection (g), Costs and Attorneys' Fees, provides a new right for a prevailing plaintiff to recover reasonable attorneys' fees and costs.

Subsection (h), Right of Action against Insurers, HMOs, Employee Benefit Plans, Self-Insurance Plans, and Other Health Care Plans or Programs, clarifies that the right of action under (a) extends not only to recovery from insurance companies, but also health maintenance organizations, employee benefit plans, self-insurance plans (except as provided in (f), managed care plans, and other health care plans that fail or refuse to pay. against managed care plans.

Subsection (i), Nonapplication of Claims Filing Requirements, is a new provision that eliminates burdensome claims processing requirements by requiring payment whenever a claim is submitted that satisfies HIPAA requirements.

Subsection (j), Application to Urban Indian Organizations, is a new provision that extends the rights under this section to urban Indian organizations.

Subsection (k), Statute of Limitations, is a new provision that provides for a specific statute of limitations on the same basis as applies to claims by IHS.

Subsection (*l*), Savings, is a new provision clarifying that the rights provided for in this section do not diminish any rights that might be available under any applicable law, including medical lien laws and the Federal Medical Care Recovery Act.

> ***Commentary.*** *The new provisions of this section are borne of experience in trying to enforce the existing rights of recovery. They are intended to clarify existing law and anticipate the newest ways in which insurers will attempt to avoid reimbursing for the services provided to their insureds.*

Sec. 404. Crediting of Reimbursements. Provides that the reimbursements received will be credited to the entity that generated them and that they may be used as provided under section 401. It continues a prohibition on offsetting the funds received under section 403 against the amount of funds otherwise due any service unit.

Sec. 405. Purchasing Health Care Coverage. Eliminates references to a study regarding tribal purchase of health care coverage and substitutes general authority for such purchases.

Sec. 406. Sharing Arrangements with Federal Agencies.

Subsection (a), Authority, continues the authority for the Secretary of HHS to enter into agreements with the Departments of Veterans Affairs or Defense to share facilities and service. New language requires consultation with the affected Indian tribes.

Subsection (b), Limitations, imposes limitations on such agreements to assure that they do not result in impairing services to the IHS beneficiaries or the access of any veteran to services of the VA.

Subsection (c), Reimbursement, is a new provision that makes the IHS the payor of last resort vis-a-vis the Veterans Affairs.

Sec. 407. Payor of Last Resort. This new section provides that IHS, tribal health programs, and urban Indian organizations are the payor of last resort notwithstanding any other federal, state, or local law to the contrary.

Sec. 408. Nondiscrimination in Qualifications for Reimbursement for Services. This new section expands a current provision that exempts IHS and tribal health programs from state and local licensing and other requirements so long as the program meets the quality standards recognized by the Secretary for furnishing such services.

Section 409. Consultation.

Subsection (a), National Indian Technical Advisory Group (TAG), is a new provision that requires the formation by the Secretary of a Tribal Technical Advisory Group (TAG) regarding Medicare, Medicaid, and SCHIP. The TAG would represent each of the 12 IHS service areas and the national organizations. It would provide advice to the Secretary regarding the way programs of CMS will affect IHS, tribal health programs, and urban Indian organizations, and about when there is a need for the Secretary to engage in more formal consultation. The TTAG would meet at least quarterly and not be subject to the Federal Advisory Committee Act.

> ***Commentary.*** *CMS has been working administratively to respond to the requests from the National Indian Health Board, the National Congress of American Indians, and the Tribal Self-Governance Advisory Work Group to form a technical work group, however absent the proposed legislative action, under FACA (and the exceptions to it), the TAG must be comprised of tribal leaders or their employees. In the highly technical area of Medicare, Medicaid and SCHIP, tribal leaders, like the governors and legislators of states, rely on technical advisors to work through the details and distill the issues for their consideration through more formal consultation. Unlike states, which are funded by CMS to maintain Medicaid programs, tribes often combine resources to employ consultants to assist their direct health care provider staff with these matters. Effective communication about these programs requires that tribal leaders have the freedom to designate who they want to participate on their behalf in technical discussions. This apparently requires legislation.*

Subsection (b), Solicitation of Medicaid Advice, is a new section that requires states in which there are Indian health programs to consult with those programs on a regular basis. It permits the cost of carrying out the requirements of this subsection to obtain administrative reimbursement from HHS under section 1903(a) of the Social Security Act.

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

Subsection (a), Authorization for Arrangements, is a new section that provides discretionary authority for the Secretary to enter into agreements with the state and the IHS or tribes under which a portion of the funds due a state can be made available to the IHS or a tribe that is providing services to individuals who are covered under the state's SCHIP, whether it is carried out through Medicaid or otherwise.

Subsection (b), Entering into Arrangements, is a new provision that authorizes the Secretary to transfer unexpended state allocations on a proportional basis to the IHS or a tribal health programs for the purpose of providing child health or other assistance to individuals served by the IHS or tribal health program consistent with the purposes of SCHIP.

> ***Commentary.*** *Both of these provisions are discretionary. The proportionate amounts provided for under (b) are almost certainly insignificant in relationship to the overall SCHIP funding and the unexpended allocations. While small from a state perspective, however, such funding as might be made available under this new section could have a very powerful effect on expanding access to health services by Indian children.*

Sec. 411. Social Security Act Sanctions.

Subsection (a), Requests for Waiver of Sanctions, is a new provision that extends the right states have to seek a waiver of sanctions against health providers to tribal health programs.

> ***Commentary.*** *This new provision was drafted to address a real situation in which IHS was willing to assist a tribal health program in supervising a board certified physician who was willing to work in a very rural health clinic that had been served previously almost exclusively by locum tenens doctors. Unfortunately, the physician was subject to a one year sanction that prevented him from working in any federally funded position absent a waiver. HHS demurred to grant the waiver, although all the substantive conditions for granting it had been satisfied, because CMS regulations permitted only states to seek a waiver of such a sanction and the state in this case would not. HHS has informally commented that this is a limitation that could be resolved through regulations, but it appears that it has not been. Although this situation arises rarely, tribal health programs should not be dependent on the cooperation of the state in which their program is carried out in order to seek a remedy from a federal agency.*

Subsection (b), Safe Harbor for Transactions between and among Indian Health Care Programs, is a new provision that authorizes certain safe harbors for transactions among IHS, tribal health programs, and urban Indian organizations, and for purposes of providing necessary transportation and housing and paying certain costs for their patients.

> ***Commentary.*** *This very narrowly written safe harbor is intended to eliminate any ambiguity about whether tribal health programs can continue to share resources after assuming the programs from the IHS. Such interactions are an integral part of the Indian health system funded by IHS and are essential to maintaining continuity of care for patients and efficient, cost effective operations.*

Sec. 412. Cost Sharing.

Subsection (a), Coinsurance, Copayments, and Deductibles, is a new provision that eliminates cost sharing requirements for patients serves in, or upon a referral from, the IHS or a tribal or urban Indian organization health program, and provides that the provider will not have its reimbursement reduced by the value of the otherwise applicable co-pay or deductible.

Subsection (b), Exemption from Medicaid and SCHIP Premiums, is another new provision that exempts Indians from the cost of premiums under the Medicaid and SCHIP programs.

> ***Commentary.*** *CMS has determined that Indian children are exempt from certain SCHIP premiums, however it has not extended that protection to Medicaid programs that may impose premiums. This would clarify and codify the exemption.*

Subsection (c), Medically Needy Program Spend-Down, is a new provision that provides that costs incurred by IHS and tribal health programs delivering care to an Indian will be attributed to the Indian for the purposes of establishing Medicaid eligibility under Medically needy options.

Subsection (d), Limitation on Medical Child Support Recovery, is a new provision that limits medical child support recovery under circumstances in which the contract health services program would have paid for the care, but for Medicaid or SCHIP eligibility.

> ***Commentary.*** *This is a very narrowly crafted provision that is intended to protect the poorest IHS beneficiaries and to achieve equity among all IHS beneficiaries regardless of whether they are Medicaid eligible or not.*

Subsection (e), Continuation of Current Law Protections of Certain Indian Property from Medicaid Estate Recovery, is a new provision that protects certain trust properties and property of unique religious or cultural significance or that is necessary to support subsistence or traditional lifestyle from estate recovery rules.

> ***Commentary.*** *This provision codifies with a small expansion existing CMS policy. It is intended to reassure elders that they make use the benefits of the Medicaid program without the risk that their heirs will lose access to this kind of uniquely Indian property. The possibility that they might have to trade their birthright in order to obtain health care they were guaranteed by treaties, executive orders, and laws acts as a nearly insurmountable barrier to access to Medicaid and causes many Indian elders to forego needed care.*

Sec. 413. Treatment under Medicaid Managed Care.

Subsection (a), Payment for Services Furnished to Indians, is a new provision that requires managed care providers to reimburse IHS, tribal health programs, and urban Indian organizations for care provided to their beneficiaries at a rate not less than that paid to the managed care entity's preferred providers or otherwise negotiated.

Subsection (b), Offering of Managed Care, is a new provision that requires states that elect to offer Medicaid through managed care to permit the IHS, tribal health programs, or urban Indian organizations that meet quality standards to be a managed care provider for the Indians it otherwise serves, without regard to other requirements that might otherwise apply.

Sec. 414. Navajo Nation Medicaid Agency. This is a new section that provides authority for the Secretary to treat the Navajo Nation as a State for the purposes of the Medicaid program and SCHIP.

SECTIONS AMENDING THE SOCIAL SECURITY ACT.

These amendments provide expanded, albeit narrowly crafted, opportunities for recovery by IHS, tribal health programs and urban Indian organizations.

Section 4. Amendments to Medicare Program.

Subsection (a), Expansion of Medicare Payment for All Covered Services Furnished by Indian Health Programs, provides for Indian health programs to be reimbursed for all Medicare services they provide, including all Part B services, rather than only for hospital and skilled nursing care and certain Part B services.

Subsection (b), Limitation on Charges for Hospital Contract Health Services Provided to Indians by Medicare Participating Hospitals, prohibits hospitals enrolled as Medicare providers charging IHS and tribal contract health programs more than Medicare reimburses. It applies to both inpatient and outpatient hospital services.

Subsection (c), Medicare Coverage of Services of Community Health Aides or Practitioners, provides for Medicare reimbursement for services provided by community health aides and practitioners. These services are currently reimbursed by Medicaid under the approved State Plan for Alaska. In the more than 100 Alaska Native villages, community health aides, who are a special provider type currently authorized only for Alaska and certified by IHS, are the only health provider in the community.

Subsection (d), Continuation of Special Treatment for Collaborative Arrangements between Indian Health Programs and Hospital Outpatient Departments, extends current rules regarding collaborative arrangements between certain outpatient clinics and inpatient hospitals within the Indian health system. These arrangements allow certain clinics that would not otherwise be considered "provider-based" under Medicare to continue to be treated as if they are for reimbursement purposes.

Subsection (e), Coverage of Visiting Nurse Services of Tribal Clinics, expands coverage for visiting nurse services by treating the programs of IHS and tribal health programs as if they were rural health clinics operating in shortage areas.

Subsection (f), Medicare Payment for Outpatient Clinics, provides for encounter rate recovery for all IHS and tribal outpatient clinics.

> ***Commentary.*** *This is an especially important provision to ensure equity of reimbursement in the IHS system. In those IHS service areas in which there are no hospitals, such as all of Idaho, Washington, Oregon, and California, all of the clinics are freestanding. As a result the basic cost of operating their program is not included in any reimbursement. The only alternative is for the clinic to bill as a federally qualified health center, which would require individual cost reports and is subject to the limitations on recovery that result in the reimbursement being demonstrably less than cost.*

Subsection (g), Review of Medicare and Medicaid Payment Systems, provides for a study of Medicare and Medicaid payment systems and continues the right of IHS and tribal health programs to be reimbursed as they currently are until prohibited by Congress.

> ***Commentary.*** *In the 1999 NSC Draft, and still in section 202 of S. 556, there is a provision to create a new provider type, a Qualified Indian Health Program (QIHP), for which reimbursement was required to cover all reasonable costs and to permit negotiation of rates to allow for increased flexibility. HHS objected to this and the Congressional Budget Office (CBO) score was the highest of any provision of the earlier draft. In an effort to respond to Administration concerns, the NSC endorsed an alternative, which is to maintain the status quo while a study of payment methodology is carried out. There are many special provider types in the Medicare and Medicaid programs; each designed to address a special challenge in assuring access to care. While it still seems the best solution to the NSC, a study will provide information upon which Congress can assess the situation more accurately.*

Section 5. Amendments to Medicaid and SCHIP.

Subsection (a), Expansion of Medicaid Payment for All Covered Services Furnished by Indian Health Programs, provides for Indian health programs to be reimbursed for all Medicaid and SCHIP services they provide. The principal effect is to eliminate reference to "facilities." It also continues to authorize the Secretary to enter into agreements with states regarding reimbursement to the state for services provided by IHS, tribal health programs and urban Indian organizations.

Commentary. *The expansion is an especially important clarification. The base of health care has changed since Medicaid recovery was first authorized in 1976. It is no longer "facility-based," but instead is often provided in the home and community.*

Subsection (b), Seeking Advice from Indian Health Programs, requires states to consult with IHS, tribes and tribal health programs and urban Indian organizations pursuant to section 409(b) of the IHCIA.

Subsection (c), SCHIP Treatment of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, provides for a 100% FMAP for all SCHIP programs, not just those carried out through Medicaid.

Provisions Found in S. 556 that Are Not in H.R. 2440.

A number of provisions found in S. 556 and the 1999 NSC Draft have been deleted or substantially recrafted. Mostly these respond to concerns about the cost or complexity of the provisions, but in some cases events have simply overtaken the initial proposal. These sections of S. 556 are discussed below.

Sec. 412. Tuba City Demonstration Project. This section was deleted because the Tuba City service unit is now under tribal management and the limitations that applied to IHS, which this section relieved, are not applicable to the tribe.

Sec. 414(b). Rulemaking. In this section, CMS was required to participate in negotiated rulemaking with tribes with regard to any regulations necessary to implement the provisions of Title IV of the IHCIA. HHS objected and the NSC agreed to withdraw it.

Sec. 416. Limitation of Secretary's Waiver Authority. This section limited certain waivers that would affect Indians. The limitation has already gone into effect.

Sec. 419(b)(2). Medicare Enrollment Premium Penalties. The NSC sought to prevent Indians from being charged late enrollment penalties that apply in the Medicare program to individuals who do not sign up for Medicare Part B at the first opportunity. Such penalties seem inconsistent with the right to access health care promised to Indians. However, in response to objections from HHS, the NSC agreed to drop this provision.

Sec. 429. Managed Care. Subsections (e), (f), (g), and (i) have been dropped for various reasons.

Title II.

Sec. 202. Qualified Indian Health Program. As noted in the discussion of section 4(g) of H.R. 2440, the creation of a new provider type was deleted in favor of a study of reimbursement methodology.

Sec. 212. FMAP for Services Provided by Indian Health Programs. Again in response to objections from HHS and the size of the CBO score, the NSC agreed to withdraw its proposed clarification of the meaning of the current provision that reimburses state Medicaid programs 100 percent of the their payments to IHS and tribal providers. The NSC still strongly supports this provision, which even in its limited application, has worked to substantially improve state/tribal relations and improve access to American Indians and Alaska Natives.

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