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

NOVEMBER 16, 2004.—Ordered to be printed

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

R E P O R T

[To accompany S. 556]

The Committee on Indian Affairs, to which was referred the bill (S. 556) to amend the Indian Health Care Improvement Act to revise and extend that Act; having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

PURPOSE

The purpose of the Indian Health Care Improvement Act Amendments of 2004 (S. 556) is to reauthorize the Act and provide a series of improvements to the Indian health care delivery system. The reauthorization is intended to raise the health status of American Indians and Alaska Natives to the highest possible level in accordance with Healthy People 2010.[1]

S. 556 sets forth policies, programs and procedures designed to address health care deficiencies in native and urban Indian communities and streamline service delivery to those communities. In addition, S. 556 addresses the health problems and associated socio-economic conditions in native communities by authorizing the Indian Health Service (IHS) and tribes to adopt current health industry "best practices".

[1] "Healthy People 2010 is the prevention agenda for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats." U.S. Department of Health and Human Services. www.healthypeople.gov. (last reviewed July 15, 2004).

39–010

BACKGROUND

First enacted in 1976, the Act established the first comprehensive framework for the delivery of health care services for native people and authorized funding for health programs, projects, and facilities. The Act was last reauthorized in 1992.

History of Federal responsibility for Indian health care

The history of the Federal responsibility for Indian health care is quite extensive and well-documented in numerous sources, including past Senate Reports on prior amendments to the Act. See eg., S. Rpt. 102–392. Nevertheless, an abbreviated history is appropriate to inform the need for reauthorizing the Act and specific provisions in S. 556.

Based on the U.S. Constitution, treaties, statutes and the historical, political and legal relationship with the Indian tribes, the United States has assumed responsibility for the provision of health care to Indian people. This jurisprudence also serves as the backdrop for the government-to-government relationship.

Extensive research indicates that the health of Indians[2] deteriorated after the contact with the European colonists as the aboriginal inhabitants had no natural immunities to the diseases carried by the new arrivals. Decades later, when Federal policy forced the Indians to relocate to reservations and, in many cases, prohibited traditional practices—including traditional healing—the health of Indians continued to plummet. Thus, health care became a particularly significant element of the treaties and other agreements between the Indian tribes and the United States.

A. Agency Administration. Initially during the early 1800s, the health care provided was little more than vaccinations for the Indians around the military posts to protect the soldiers and non-Indians from the possibility that Indians might spread diseases. During the late 1800s, physicians and hospitals were added to the reservations and other outposts.

According to the Task Force on Indian Health (Task Force Six) in the Final Report to the American Indian Policy Review Commission (Final Report), "[t]he health care which Indians actually received in the first 100 years was delivered in a piecemeal, inconsistent fashion and the few appropriations made were never large enough to meet the overwhelming need." Final Report at 27.

This lack of focus and priority was compounded by an ever-shifting administration of Indian health among the different Federal agencies. The responsibility for Indian health first fell to the War Department in 1803, then to the Interior Department in 1849, before finally being transferred to the Department of Health, Education and Welfare (DHEW), the predecessor of the DHHS, in 1955. The Division of Indian Health within DHEW had initial responsibility for Indian health before eventually being renamed the Indian Health Service. Id. at 32.

B. Congressional Action. In 1921, Congress enacted the Snyder Act, 25 U.S.C. 13, to provide for permanent appropriations authority for Indian health programs and services. However, the Snyder Act did not provide meaningful standards by which to measure progress in Indian health status or other improvements in services.

[2] As the term is used in this Report, "Indians" includes American Indians and Alaska natives.

Shortly after the responsibility for Indian health was transferred to DHEW, Congress passed the Indian Sanitation Facilities and Services Act, 42 U.S.C. 2004, which authorized the IHS to provide sanitation facilities to Indian communities. These sanitation facilities were critical to eliminating many health maladies associated with the lack of proper sanitation, such as dysentery and infectious hepatitis.

The lack of standards in the Snyder Act and other organized efforts led Task Force Six to conclude in 1976 that "there [was] no clear overall direction or policy for implementation of the various programs. As a result, the Indian Health Services operates primarily an emergency and crisis oriented service. * * * This has resulted in increased prevalence of certain health deficiencies which are virtually unknown in the general population." Final Report at 27.

C. The Indian Health Care Improvement Act. Congress sought to end the piecemeal approach to Indian health and to provide meaningful direction with passage of the Act in 1976. The Act has been revised and extended three times since then, each time providing for additional advancements to raise the status of Indian health.

Specific Provisions. Several important provisions were included as part of the comprehensive framework for improving Indian health. First, manpower training, recruitment and retention programs were established to increase the number of health professionals, especially Indians, in the Indian health care system. 25 U.S.C. 1612.

Urban Indian Programs. In addition, the Act recognized the need for urban Indian health programs, with many Indians located in urban centers because of the Federal relocation policy pursued in the first half of the 20th Century. Many disparities urban Indians face can be attributed to that Federal policy. See Final Report at 142–145.

Congress acknowledged that the Federal obligation for Indian health care did not end at the border of the reservation—even though relocation was initially to end services to these urban Indians[3] rather than to improve the status of Indians (health, economic) in a meaningful way.[4] See also S. Rpt. 100–508 at 25.

Congress specifically included urban Indians as part of the Indian health care system in the Act in 1976 to correct these disparities first as pilot programs and then "as a permanent part" of the Indian health care system in 1988. S. Rpt. 100–508, at 24. Congress has expanded health services to urban Indians since 1976. See Pub. L. 100–713, 101–630, and 102–573.

Providing for urban Indian health has been a part of Federal policy for more than 30 years. The definition of "urban Indian" remains the same in S. 556 as in current law and is well within the scope of Congressional authority to establish such definition.

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[3] Relocating Indians from reservations to urban areas is an old Federal policy and program first begun in 1931. "Relocation complemented other termination programs designed to promote rapid assimilation. Once relocated, Indians were cut off from the special federal services that had been available to them as reservation residents." Id.

[4] The Snyder Act, 25 U.S.C. 13, authorizes funding for health care for "the Indians throughout the United States". This statute neither confined the services to individuals who were members of federally-recognized tribes nor to those living only on reservations. The Snyder Act has never been repealed or otherwise limited in this respect.

This definition does not create unlawful racial classifications simply because "urban Indians" include individuals who are members of a federally-recognized Indian tribe and, in some cases, individuals who are not enrolled members of any federally-recognized Indian tribe.

The view that only members of federally-recognized tribes are eligible for such services has been thoroughly disavowed by Congress and the courts. First, Congress has very broad powers "to define who are Indians" through its power to regulate commerce with Indian tribes.[5] Second, Congress has defined "Indians" in different ways under various statutes for different purposes. See e.g., Indian Arts and Crafts Act, Pub. L. 101–644, 25 U.S.C. 305; and No Child Left Behind Act, Pub. L. 107–110, 20 U.S.C. 7491; and the American Indian Probate Reform Act of 2004, Pub. L. 108–374, signed into law on October 27, 2004.

One such definition found in the Indian Reorganization Act of 1934, 25 U.S.C. 477, did not include the requirement of membership in any tribe and was upheld in *U.S.* v. *John,* 437 U.S. 634 (1978). Courts have upheld the broad Congressional power in other contexts as well. Most recently, the court in *U.S.* v. *Drewry,* 365 F.3d 957, 961 (10th Cir. 2004) held that "enrollment in a tribe is not the only way an individual can show she is an Indian" for Federal criminal jurisdictional purposes. The Drewry court cited a litany of cases which also support the principle that "Indianness" is not limited to membership in a federally-recognized tribe. See e.g., *U.S.* v. *Antelope,* 430 U.S. 641 (1997).

Certainly the courts have not held that the breadth of Congressional power in Indian affairs is expansive only when legislating to the detriment of Indians. To the contrary, Courts have long held with great favor that Congress has the broad power to legislate for the benefit of Indians and to define who is an Indian.

The history, policy and status of Indian health provide ample support for continuing and improving programs to urban Indians and, therefore, the Committee stands firm on not retreating from current law; and remains committed to improving the health care of urban Indians in this legislation.

Indian health status

A. Health Status. The health status of Native Americans has improved significantly since the enactment of the Act in 1976, but the statistics remain grim. The goal of the Act was to raise the health status of Indians to achieve parity with that of other U.S. populations. With the basic goal still unrealized, the need for reauthorization grows even greater.

Health Indicator Rates. Indians rank at or near the bottom of nearly every health and social indicator when compared to the general U.S. population. Health studies indicate disproportionately higher mortality rates for alcoholism (between 670–770%), tuberculosis (650%), diabetes (between 318–420%), accidental injuries (280%), suicide (190%), and homicide (210%) than other populations. In addition to these specific health disparities, native people suffer from high rates of unemployment and poverty, live in

[5] U.S. Const., Art. I § 8, cl. 3. See also Cohen, Felix. Handbook of Federal Indian Law, at 23. 1982 ed.; *U.S.* v. *Holliday*, 70 U.S. 407, 417 (1865) (The broad power also includes Congress; dealings with individual Indians).

substandard housing, and receive an inadequate education[6]—all of which contribute to poor health.

Alcohol and Substance Abuse. Native communities are increasingly plagued by mental health problems, including those exacerbated by the use of alcohol and substances, at staggering rates which destroy native families. Federal programs currently offer several disparate and uncoordinated mental health, and alcohol and substance abuse prevention and treatment programs. Better coordination of these programs within a comprehensive behavioral health program will not only bring greater benefits to native people, but will make a more efficient and effective use of scarce resources.

Prevention. Long-term prevention efforts would also significantly improve the health status of Indians. Many programs have focused on treatment due, in part, to the progressive, degenerative or advanced nature of the diseases. However, many of the diseases which plague native communities are preventable, such as diabetes, and their prevention would reduce the long-term costs to the health care system. More attention is needed to programs focusing on health promotion and disease control and prevention.

B. Health Care System. Since the Act was first passed, the Indian health care system has undergone significant changes, particularly in the tribal administration of services. Through the Act, combined with the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA) in 1975, 25 U.S.C. 450, et seq., Indian tribes gained the means to administer Indian health programs.[7]

However, that means is sometimes thwarted by cumbersome bureaucracy and narrow interpretations of the ISDEAA. The ISDEAA authorizes Indian tribes or tribal organizations to administer programs previously operated by the IHS.

Tribal Administration. As part of that administration, Indian tribes or tribal organizations enter contracts or compacts with the IHS through which they may also incorporate grants or redesign programs. 25 U.S.C. 450f and 458aaa–4. Administering such contracts allows the tribal contractors to save significant administrative costs and increase services to tribal members.[8]

The Committee has received testimony regarding the need to clarify that this funding transfer mechanism for Indian health programs is available for grants under the Act as well. However, the Committee does not intend to diminish the Secretary's discretion to award grants under the Act.

The Committee also intends that those programs that were grants in current law (i.e., the Act as passed in 1992) remain as grants, unless the Secretary determines they are appropriate, contractible functions. However, nothing in S. 556 is intended to modify in any way the Indian tribes authority under ISDEAA to in-

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[6] U.S. Department of Health and Human Services, Indian Health Service, Facts on Indian Health Disparities, 2002.

[7] In FY 2005, the IHS projects that "approximately $947 million of program and tribal shares finds will be transferred to support 87 compacts." Department of Health and Human Services, Fiscal Year 2005, Indian Health Service, Justification of Estimates for Appropriations Committee (Justification) at 129.

[8] Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management, National Indian Health Board, Vol. II at 32.

corporate a grant after it has been awarded in an ISDEAA Title I or Title V agreement.

Flexibility is a hallmark in the delivery of Indian health care, for both the DHHS and Indian tribes. In S. 556, the Committee included the definition of "fund" and "funding agreement" to make clear that the funding mechanisms available for Indian health programs include a wide range of options, such as contracts or compacts under the ISDEAA as well as grants.

The ISDEAA refers to "annual funding agreements" and "funding agreements" under Titles I (25 U.S.C. 450) and V (25 U.S.C. 458aaa), respectively, and those terms are both contemplated within the Act's definition of "funding agreement" to complement, not conflict with, each other. The Committee encourages the use of contracts and compacts to enable tribal contractors to save costs, but recognizes that certain grant requirements or conditions may still be appropriate and incorporated into those legal agreements. The Committee believes that these principles will improve the administration of Indian health.

Services. According to the IHS, the Indian health programs are administered by the IHS directly, Indian tribes, tribal organizations and urban Indian organizations, serving over 1.6 million Indians. Justification at 15.

According to the IHS, "there are 594 direct health care facilities, including 51 hospitals, 231 health centers, 5 school health centers, and 309 health stations, satellite clinics and Alaska village clinics." Justification at 15.

The services include inpatient and ambulatory care with an increased focus on preventive care. More specialized care may be provided through contract health services wherein the IHS contracts with non-IHS providers for these services.

Community Health Aide Program. The Community Health Aides/Practitioner Program (CHAP) was established several years ago under the authority of the Snyder Act to address the severe shortage of health professionals in Alaska. The program has operated with much success and has received substantial support from the Administration. The success of the CHAP has led the Committee to authorize the development of a national CHAP.

Based on the success of the medical component of the CHAP, a dental component has been developed to address the oral health crisis in Alaska. The Committee is aware that several practitioners are currently in a 2-year training program for certain dental procedures. Once they complete their training, they will be under supervision of a licensed dentist until they have been certified to provide certain dental procedures.

However, the American Dental Association (ADA) expressed concerns regarding the training of the CHAPs in providing so-called "irreversible procedures" for Indians.

The Committee recognizes there should be a balance of quality care and access to care in developing these programs. Arguably, without such programs, many Alaska natives will have no dental care whatsoever.

The Committee also recognizes that developing a dental volunteer program as the ADA has suggested to the Committee may provide temporary relief to the crisis, but may not be sufficient to address the real need or have funding available even for a "volunteer"

program. The Committee also understands that the IHS's dental priority in the Indian communities located in the lower 48 states is to fill vacancies with dentists and the national CHAPs program is not slated to begin in the near future.

Therefore, the Committee strongly encourages the Administration, the Indian tribes and the ADA to work together to address the need and fill the vacancies within the Indian health care system.

Elevation. While Indian health care has received increased attention by the Administration by accentuating the role of the Director of IHS among other things—institutionalizing that role is important. Bringing a heightened role to the IHS is needed to improve advocacy efforts for Indian health care and coordination with other agencies in improving the health status of Indians. Accordingly, S. 556 includes a provision to elevate the position of Director to that of Assistant Secretary—Indian Health.

Funding. Funding is one area where additional advocacy could assist. Indian health has received incremental increases in funding over time. According to the U.S. Commission on Civil Rights, the funding has grown from $24.5 million in 1955 to $3.5 billion in 2004. See U.S. Commission on Civil Rights, A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country (2003) at 40. Yet, according to some estimates, the actual need approaches $10 billion per year over the next 10 years, with "a one-time appropriation of $8 billion for facility construction * * *." Id. at 49.

Third Party Reimbursements. The ability of IHS, Indian tribes, tribal and urban Indian organizations to access third party reimbursements, such as Medicaid, becomes even more important. Several Indian-specific provisions had been included in the Medicare Prescription Drug and Modernization Act of 2003, Pub. L. 108–173, and, therefore, additional amendments recommended by the National Steering Committee (NSC), which was constituted to facilitate reauthorization, were not included in the reported bill.

However, the decision not to include those provisions in this legislation should not be viewed as a rejection of them on the merits. The Committee expects that these Indian-specific provisions for Medicare will be considered when future amendments are considered to Medicare.

Payment systems have been the subject of much debate during the development of this legislation. The study on the extent Social Security Act payment methodologies take into account the unique circumstances of Indian health services was not included in the reported bill. The DHHS indicated to the Committee that it has sufficient authority under existing law to undertake this payment methodology review.

Thus, the Committee is confident the Secretary will perform such a review pursuant to existing authority. The Committee encourages the Secretary consider current payment methodologies applicable to the Indian health system with the objective of balancing access to care and payment at rates consistent with those for most favored providers.

The Committee is aware that the costs of changing to a different payment methodology could cost the IHS and Indian tribes up to $16 million. Therefore, in the interim, the Committee expects the Secretary to maintain the current pay rate unless another rate is determined by the Secretary to be more beneficial to Indian health

programs, given the additional costs associated with the new system.

The Committee is aware that Indian tribes have sought to interface with Medicaid managed care organizations (MCO) or to develop their own tribal MCO. The primary goals for participation are to ensure the appropriate entities achieve the full benefit of the Medicaid funding, particularly the capitated payments, and increase access for Indians to these programs.

First, when an Indian—enrolled in a MCO authorized by a State Medicaid Plan—receives covered health services from an Indian health program, the MCO should reimburse the Indian health program appropriately.

The rate should be no less than the rate of reimbursement for preferred providers or at such other rate that may be negotiated between the MCO and the Indian health program. In the alternative, the State Medicaid Plan may make the appropriate payments to the Indian health program, and then make an adjustment in the capitation payment to the MCO.

The Committee is aware that Medicaid Indian patients may be enrolled in Medicaid MCOs for which the State Medicaid Plan makes capitation payments to the MCO. Often such an Indian enrollee will use the Indian health program for needed health care, especially when the MCO network providers are distant from or unfamiliar to the patient.

Having received a capitation payment from the Medicaid Plan, the MCO should not be permitted to escape responsibility for reimbursing the Indian health provider when the MCO has not included the Indian health program in its provider network, yet has received Medicaid funding as a result of that Indian's enrollment in the Plan.

The Committee is aware that some Indian health programs have attempted to join the network, but have been met with some resistance or, in the end, have found it not feasible to join. The Committee believes the Indian health programs should not be treated disparately in payment. Thus, S. 556 fosters cooperative efforts in increasing access and payment equity.

Streamlined Bureaucracy. In addition to these third party reimbursements, streamlining bureaucracy—which provides residual increases to the aggregate health care funding—is also needed.

Program Administration. Throughout S. 556, the Committee has identified many priorities and programs upon which the IHS and tribes should focus. The Committee also believes that flexibility in program administration is needed to improve the health status of Indian people and is best achieved by allowing Indian tribes and the IHS to determine these matters at the local level.

Such determinations may be made through a variety of tools available to the IHS and Indian tribes such as consultation and negotiated rule-making. The Committee particularly favors negotiated rule-making, pursuant to 5 U.S.C. 561, et seq., in developing the various program elements for several reasons.

First, the Indian tribal and urban health providers—as first responders in the health system—should have direct involvement in developing these programs and the regulations that govern those programs. Second, tribal involvement leads to a more informed rule and fosters tribal support.

Finally, negotiated rule-making saves costs to all parties in the long run. By building a higher level of consensus in the regulations, the IHS lowers the potential for legal challenges to the rules and associated litigation costs. The Committee favors the consensus-building procedure over litigation and has found it to be useful in other initiatives such as education, housing and self-governance.[9]

The Committee recognizes that the Administration has renewed efforts to involve Indian tribes in decision-making, but the Committee remains committed to promoting tribal input by institutionalizing such efforts.

National Steering Committee

In June, 1999, the Director of the IHS convened the NSC comprised of tribal leaders and representatives from Indian health organizations to consult on the reauthorization. The NSC held a series of meetings in 1999 during which extensive discussions were held between the NSC and DHHS officials.

In the meantime, the tribal officials of the NSC set out to craft a comprehensive reauthorization. During the drafting of this legislation, the tribal officials obtained technical assistance from various DHHS officials.

The draft document produced served as the basis for predecessor bills S. 2526 (106th Congress) and S. 212 (107th Congress). Neither bill was enacted, but S. 212 did receive significant attention from the Administration.

By letter dated September 27, 2001, the Administration provided its views on S. 212 to the Committee. During 2002, tribal officials and Committee staff reconvened to address the Administration's concerns. The entire set of proposals was not finalized in time to be incorporated into S. 556 upon introduction.

But due to the size and importance of the legislation, the Committee was compelled to begin addressing the issues surrounding the reauthorization. The proposed revisions were completed in May, 2003, and have been largely incorporated into the substitute amendment to S. 556 which was favorably reported by the Committee.

Prior legislative activity

The reauthorization of the IHCIA has been a work in progress since the 106th Congress when Senator Campbell introduced S. 2526, the Indian Health Care Improvement Act Reauthorization of 2000 for himself and for Senators Inouye and McCain. S. 2526 was favorably reported by the Committee to the full Senate, but no further action was taken.

During the 107th Congress, Senator Campbell introduced S. 212, the Indian Health Care Improvement Act Reauthorization of 2001, on January 30, 2001 for himself and for Senators Inouye and McCain. The bill was co-sponsored by Senators Johnson, Dorgan, Daschle, Feinstein, and Murray.

The bill was referred to the Committee, but not reported out.

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

SUMMARY OF MAJOR PROVISIONS

TITLE I. INDIAN HEALTH MANPOWER

The purpose of Title I is to increase, to the maximum extent feasible, the number of American Indians and Alaska Natives entering the health professions and to ensure an adequate supply of health professionals to the IHS, tribal and urban Indian health programs.

This title covers recruitment, scholarships, extern programs, continuing education, community health representatives, loan repayment, advanced training and research, nursing, tribal cultural and history, inmed, health training, incentives, residency and community health aides.

TITLE II. HEALTH SERVICES

The purpose of Title II is to establish programs that respond to the health needs of Indians. This title has a specific diabetes provision which complements the Special Diabetes Program for Indians authorized pursuant to the Balanced Budget Act of 1997.

It also governs the Indian Health Care Improvement Fund through which Appropriation Acts supply funds to eliminate health deficiencies and disparities in resources made available to Indian tribes and communities.

This title also contains a catastrophic health emergency fund; health promotion and disease prevention services; hospice feasibility; research; mental health; managed care feasibility; Arizona, North Dakota, South Dakota, Trenton and California contract health services programs; mammography; patient travel; epidemiology; school health education; Indian youth; psychology; tuberculosis; environmental and nuclear health hazards, and women's health.

TITLE III. FACILITIES

The purpose of Title III relates to the construction of health facilities, including hospitals, clinics, and health stations, necessary staff quarters, and of sanitation facilities for Indian communities and homes. It also would require the Government Accountability Office (GAO) to conduct a comprehensive needs report on Indian health needs for inpatient, outpatient and specialized care facilities. It also would require newly-constructed/renovated facilities, whenever practicable, to meet the construction standards of any nationally-recognized accrediting bodies.

TITLE IV. ACCESS TO HEALTH SERVICES

The purpose of Title IV is to address payments to the IHS and tribes for services covered by the Social Security Act Health Care programs, and to enable Indian health programs to access reimbursements from third party collections.

This title includes provisions to increase Indian enrollment and participation in the third party health services, including tribal outreach programs and advisory groups.

TITLE V. HEALTH SERVICES FOR URBAN INDIANS

The purpose of Title V is to establish programs in urban centers to make health services more accessible to Indians who live in

urban areas. This title authorizes the Secretary to enter into contracts or grants to urban Indian organizations to administer health programs and sets forth basic requirements.

This title also establishes the Office of Urban Indian Health to provide central oversight of the programs and services. Title V also extends Federal Tort Claims Act coverage to urban Indian organizations and provides access to the Federal sources of supply for pharmaceutical purchases.

TITLE VI. ORGANIZATIONAL IMPROVEMENTS

Title VI changes the "Director—IHS" to the "Assistant Secretary—Indian Health". This title also authorizes the Secretary through the IHS to establish an automated management information system as well as other duties as assigned by the Secretary for the IHS.

TITLE VII. BEHAVIORAL HEALTH PROGRAMS

Title VII is revised from current law (which only addresses substance abuse programs) to provide a comprehensive focus on behavioral health. It combines all substance abuse, mental health and social service programs in one title and integrates these programs to enhance their performance and efficiency.

The IHS is to provide comprehensive alcohol and substance abuse prevention and treatment programs, rehabilitation and aftercare services, an IHS youth program, and training and community education. Demonstration projects are outlined as well as grants focusing on Fetal Alcohol Syndrome and Fetal Alcohol Effect. It also expands the authorization to establish inpatient mental health facilities in each IHS Area.

The title also addresses the responsibilities of the IHS as outlined by the Memorandum of Agreement pursuant to section 402 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986. The IHS will determine the scope and need for substance abuse programs and estimate adequate funding.

This title authorizes funding for development of innovative community-based behavioral health services, including child sexual abuse programs.

TITLE VIII. MISCELLANEOUS

The purpose of Title VIII is to address miscellaneous topics including a compilation of the reports required under the Act. It also applies the Negotiated Rulemaking Act to various activities under the Act. Other provisions require the Secretary to develop a plan of implementation to submit to Congress. This title also describes the eligibility of California Indians for IHS services and authorizes a Commission to study the issue of Indian health funding as an entitlement.

LEGISLATIVE HISTORY

Legislative activity

During the 108th Congress, Senator Campbell introduced S. 556, the Indian Health Care Improvement Act Reauthorization of 2003, on March 6, 2003, for himself and for Senators Inouye and McCain. The bill was referred to the Committee on Indian Affairs which, as

noted below, immediately began holding hearings to advance the legislation.

On July 17, 2003, Senator Johnson was added as a cosponsor. Senator Murray was added as a cosponsor on June 3, 2004, and Senator Daschle was added as a cosponsor on June 24, 2004. Senator Bingaman was added as a cosponsor on September 23, 2004. On September 24, 2004, Senator Dorgan was added as a cosponsor. Senator Murkowski was added as a cosponsor on October 10, 2004 and Senator Cantwell was added as a cosponsor on November 17, 2004.

On the House side, Congressman Don Young introduced a companion bill, H.R. 2440, Indian Health Care Improvement Act Amendments of 2003 on June 11, 2003.

Hearings held during the 108th Congress

The Committee held eight hearings overall since the 106th Congress on the reauthorization of the Act and four hearings during the 108th Congress.

On April 2, 2003, the Committee held its first hearing in the 108th Congress to reauthorize the IHCIA, addressing the "One-HHS" initiative and the need for reauthorization. The witnesses included DHHS and members of the NSC.

On July 16, 2003, the Committee held the second hearing—jointly with the House Resources Committee—which addressed health disparities, sanitation facilities and urban Indian clinics. Witnesses included representatives from the Department of Housing and Urban Development (DHUD), DHHS, the NSC, Alaska Native Tribal Health Consortium, Association of American Indian Physicians, and Urban Indian Health Clinics.

On July 23, 2003, the Committee held the third hearing to receive testimony on Medicaid and Medicare issues from representatives from Indian tribes, tribal health clinics and Indian health consultants. The DHHS was invited, but provided no witness for the hearing.

To complete the series of hearings and expedite the mark-up of this legislation, the DHHS was informally invited to testify on the Medicaid and Medicare issues for possible Fall, 2003 and Spring, 2004 hearings. However, the DHHS demurred.

Finally, on July 21, 2004, Secretary Thompson testified before the Committee regarding the Administration's views on the proposed legislation. At this hearing, the Secretary expressed enthusiastic support of the reauthorization and his desire to see it enacted before the end of 2004.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In an open business session on September 22, 2004, the Committee considered a substitute amendment proposed by Senator Campbell. By a unanimous vote, the Committee ordered the substitute amendment favorably reported to the full Senate with the recommendation that the bill do pass.

SECTION-BY-SECTION ANALYSIS

Section 1. Short Title. Section 1 provides the short title of the act as the "Indian Health Care Improvement Act Amendments of 2004".

Section 2. Indian Health Care Improvement Act Amended. Section 2 sets forth the provisions of the Act beginning with section 1 and ending with section 818. The following section numbers of this analysis reflect the section numbers of the Act.

Section 1. Short Title; Table of Contents. Section 1 sets forth the short title and table of contents.

Section 2. Findings. Section 2 sets out Congressional findings for the Act by providing a historical context for Federal-tribal relations; a context to the framework of Indian health; and a summary of the history, testimony, evidence, research and other information relevant to the development of the Indian health care system.

Section 3. Declaration of National Indian Health Policy. This section declares the national policy to be the fulfillment of the special trust responsibility and legal obligation to Indians, and to continue to improve the health status of Indian people.

Section 4. Definitions. Section 4 provides definitions for terms used throughout the Act. New definitions for the terms "Fund or funding" and "Funding Agreement" were added to provide clarity and reflect current practice and administration of Indian health programs.

The term "health profession" includes a wide variety of practices. The Committee provides the list as examples of the primary types of professions employed throughout the Indian health system. However, the Committee recognizes that the IHS, Indian tribes or urban Indian organizations may need flexibility in including an appropriate health profession to meet the local needs and based on availability of funding.

TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

Section 101. Purpose. This section states the purpose of this title is to increase the number of Indians entering the health professions and to assure an optimum supply of health professionals to provide health services to Indians.

Section 102. Health Professions Recruitment Program for Indians. Section 102 authorizes funding for recruitment programs to include such activities as identifying Indians with potential for entering health professions, publicizing funding sources, and establishing programs to facilitate enrollment in applicable courses of study.

This section may also include appropriate intern or temporary employment programs during any nonacademic period of the year. However, these programs are not designed to be summer employment programs, but rather are to increase the stability of health professional employment. This section also addresses funding applications and amount of funding to be provided, as well as defining who is an Indian for purposes of sections 103 and 104.

Section 103. Health Professions Preparatory Scholarship Program for Indians. Section 103 authorizes scholarships to Indians for compensatory preprofessional education as well as pregraduate

education leading to a baccalaureate degree in a preparatory field for a health profession.

Section 103 also prohibits denial of a scholarship based solely on scholastic achievement if the applicant has already been admitted or maintains good standing at an accredited institution or if the applicant is eligible for assistance under another Federal program.

Section 104. Indian Health Professions Scholarships. Section 104 authorizes scholarships to Indians who are enrolled full- or part-time in accredited schools pursuing courses of study in the health professions. Such scholarships are designated as Indian Health Scholarships. The section further sets forth how the funding for these scholarships is to be allocated and addresses all the requirements of the active duty service obligation incurred as a result of the scholarship, including breach of contract situations.

Section 105. American Indians Into Psychology Program. This section authorizes grants to at least 3 colleges and universities for developing and maintaining Indian psychology career recruitment programs. The Quentin N. Burdick Program Grant at the University of North Dakota is authorized specifically. This section directs the Secretary to issue regulations for competitive funding, specifies conditions of the grants and active duty service requirements.

Section 106. Funding for Tribes for Scholarship Programs. Section 106 authorizes the Secretary to make funds available to Tribal Health Programs for the purpose of educating Indians to serve as health professionals in Indian communities. The requirements for receiving such funds; the course of study; contract conditions; specific parameters for a breach of contract; the relationship of a scholarship under this section to the Social Security Act; and conditions of continuance of funding are all specified in this section.

Section 107. Indian Health Service Extern Programs. Section 107 gives preference for employment in the IHS, a Tribal Health Program, Urban Indian Organization or other agencies within the Department, to any recipient of a scholarship pursuant to section 104 or 106. The section specifies that such employment does not count toward any active duty service obligation. It specifies the timing and length of employment and exempts the program from any competitive personnel system or agency personnel limitation. The section further specifies that an individual employed under this section will receive practical experience in the health profession in which he or she is studying.

Section 108. Continuing Education Allowances. This section authorizes the Secretary to provide allowances to health professionals employed in an Indian Health Program or an Urban Indian Organization to enable them to take leave of their duty stations for a period of time each year for professional consultation and training courses.

Section 109. Community Health Representative Program. Section 109 authorizes the Community Health Representative Program for training and using Indians as community health representatives. The section specifies the duties of the IHS regarding this program, including providing a high standard of training for Community Health Representatives to ensure that these representatives provide quality health services to Indian communities.

Section 110. Indian Health Service Loan Repayment Program. This section establishes the Indian Health Service Loan Repay-

ment Program to ensure an adequate supply of trained health professionals to maintain accreditation of and provide health care services to Indians. The section specifies eligibility for the program; application information; priorities; recipient contracts; deadlines for decision on applications; a loan repayment program; a waiver from any employment ceiling; a recruitment program; non-applicability of section 214 of the Public Health Service Act; assignment of individuals; breach of contract; waiver or suspension of obligation; and requires an annual report to Congress under section 801.

Section 111. Scholarship and Loan Repayment Recovery Fund. Section 111 establishes an Indian Health Scholarship and Loan Repayment Recovery Fund within the Treasury of the United States. The section specifies the use of these funds, the investment of the funds, and the sale of obligations by the Secretary of the Treasury. The Administration expressed concerns with investing appropriated funds as being inconsistent with standard Federal investment policy. Provisions were added to expressly exclude the investment of Federally-appropriate funds. However, other types of funds may still be invested as needed.

Section 112. Recruitment Activities. Section 112 permits the Secretary to reimburse certain travel expenses to health professionals seeking positions with Indian Health Programs or Urban Indian Organizations. Unpaid volunteers, potential candidates for contracts under section 110, and their spouses are all eligible for such reimbursement of travel. In addition, this section requires the Secretary to assign one individual in each Area Office to have full-time responsibility for recruitment activities.

Section 113. Indian Recruitment and Retention Program. Section 113 requires the Secretary to fund innovative demonstration projects to enable Tribal Health Programs and Urban Indian Organizations to recruit, place, and retain health professionals to meet their staffing needs. The section also specifies that any Tribal Health Program or Urban Indian Organization is eligible to apply for these funds.

Section 114. Advanced Training and Research. This section establishes a demonstration project to enable certain health professionals to pursue advanced training or research area of study, where a need exists, for a substantial period of time. The section specifies a service obligation and equal opportunity for participating in the program.

Section 115. Quentin N. Burdick American Indians Into Nursing Program. Section 115 authorizes the Quentin N. Burdick American Indians into Nursing Program for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians. The section specifies potential grant recipients; how grants may be used; information which must be included in applications for the grant; preferences for grant recipients; establishment and maintenance of a program at the University of North Dakota; and an active duty service obligation.

Section 116. Tribal Cultural Orientation. This section requires certain employees of the IHS who serve Indian Tribes in each Service Area to receive instruction in the history and culture of the tribe they serve. The section requires the Secretary to develop such a program in consultation with the affected Indian entity, to be implemented through tribal colleges or universities, include instruc-

tion in American Indian studies, and describe the use and place of Traditional Health Care Practices.

Section 117. INMED Program. Section 117 authorizes the Secretary to provide grants to colleges and universities to maintain and expand the Indian health careers recruitment program (Indians Into Medicine Program). The Quentin N. Burdick Grant is one of the authorized grants. This section also specifies requirements for institutional applicants for these grants.

Section 118. Health Training Programs of Community Colleges. This section requires the Secretary to award grants to accredited, accessible community colleges to assist in establishing health profession education leading to a degree or diploma for individuals who desire to practice such profession on or near a reservation or Indian Health Program. The Secretary is also required to award grants to accredited, accessible community colleges that already have these programs. The Secretary must provide technical assistance to encourage community colleges to establish and maintain such programs. Finally, any program receiving assistance under this section is required to provide advanced training for health professionals. Funding priorities are provided to tribal colleges and universities in Service Areas where they exist.

Section 119. Retention Bonus. Section 119 permits the Secretary to provide retention bonuses to certain health professionals. Rates for retention bonuses and conditions for default of retention agreement are also specified.

Section 120. Nursing Residency Program. This section establishes a program to enable Indians who are nurses working for an Indian Health Program or Urban Indian Organization to pursue advanced training. Eligibility, program parameters and service obligations are specified.

Section 121. Community Health Aide Program for Alaska. Section 121 directs the Secretary to develop and operate the CHAP in Alaska. Requirements and criteria are specified for the Alaska program. In addition, the Secretary is authorized to develop and operate a similar program on a national basis without reducing funds for the Alaska program.

Section 122. Tribal Health Program Administration. This section requires the Secretary to provide training for Indians in the administration and planning of Tribal Health Programs.

Section 123. Health Professional Chronic Shortage Demonstration Programs. In this section the Secretary is authorized to fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals. Each demonstration program shall incorporate a program advisory board composed of representatives from the tribes and Indian communities which are served by the program.

The Indian tribes recommended automatic designation of shortage areas under 42 U.S.C. 250, et seq., upon request by the Indian tribes. The Committee has been made aware that tribal applications receive little or no attention and, therefore, Indian communities cannot receive the benefit of the designation.

However, the Administration objected to the automatic designation and instead committed to working with the Indian tribes and the Health Resources and Services Administration to assist them in achieving such designation. The Committee is pleased with this

commitment and will look forward to hearing the status of tribal applications in the future.

Section 124. Treatment of Scholarships for Certain Purposes. Scholarships provided under this section are deemed "qualified Scholarships" for purposes of section 11 of the Internal Revenue Code of 1986. Such designation means the scholarship funds are not considered taxable income of the recipient.

Section 125. National Health Service Corps. This section prohibits the Secretary from removing a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization or withdraw funding to support such member unless the Secretary ensures that Indians will experience no reduction in health services. The section also exempts National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service from full-time equivalent limitations when serving as a Commissioned Corps officer in a Tribal Health Program or an Urban Indian Organization.

Section 126. Substance Abuse Counselor Educational Curricula Demonstration Programs. Section 126 authorizes the Secretary to enter into contracts or make grants to accredited colleges and universities to establish demonstration programs developing curricula for substance abuse counseling. Duration and renewal of the grant is specified. The section also establishes the criteria for review and approval of the applications, requires the Secretary to provide technical and other assistance to grant recipients, requires the Secretary to submit an annual report to the President under section 801 and defines the term "educational curriculum".

Section 127. Behavioral Health Training and Community Education Programs. This section requires the Secretary, with the Secretary of the Interior and in consultation with Indian Tribes and Tribal Organizations, to conduct a study and compile a list of certain types of staff positions within the Bureau of Indian Affairs, the IHS, Indian Tribes, Tribal Organizations and Urban Indian Organizations, which should include training in any aspect of mental illness, dysfunction, or self destructive behavior.

The Secretary is then required to provide training criteria appropriate for each type of position and ensure that this training is provided. On request of the appropriate Indian entity, the Secretary is required to develop and implement a program of community education on mental illness, as well as technical assistance to tribal entities to develop community education materials.

Within 90 days of enactment, the Secretary is required to develop a plan to increase behavioral health services by at least 500 staff positions within 5 years, with at least 200 of such positions devoted to child, adolescent, and family services.

Section 128. Authorization of Appropriations. Section 129 authorizes appropriations as are necessary to carry out this title for each fiscal year through 2015.

TITLE II—HEALTH SERVICES

Section 201. Indian Health Care Improvement Fund. This section authorizes the use of funds for the purposes of eliminating the deficiencies in health status and resources for tribes; eliminating backlogs and meeting the needs in health care services; eliminating the inequities in funding for direct care and contract health service

programs; and augmenting the ability of the IHS to meet its various responsibilities. Funding authorized by this section may not be used to offset appropriated funds and must be used to improve the health status and reduce the resource deficiencies of tribes.

This section also provides definitions applicable to this section and requires that Tribal Health Programs be equally eligible for funds as the IHS. A report is required to be submitted to Congress 3 years after enactment which addresses the current health status and resource deficiency for each Service Unit. Funds appropriated under this section are to be included in the base budget of the Indian Health Service for determining appropriations in subsequent years.

Finally, nothing in this section is intended to diminish the primary responsibility of the Indian Health Service to eliminate backlogs in unmet health care nor to discourage additional efforts of the IHS to achieve equity among tribes and tribal organizations.

Section 202. Catastrophic Health Emergency Fund. Section 202 establishes the Catastrophic Health Emergency Fund (CHEF) to be administered by the Secretary through the central office of the IHS in order to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses.

No part of the CHEF or the administration thereof are to be subject to contract or grant, nor shall these funds be apportioned on an Area Office, Service Unit, or other similar basis. The Secretary is required to promulgate regulations for the administration of these funds through negotiated rulemaking.

This section requires that funds appropriated to CHEF not be used to offset or limit other appropriations made to the IHS. It also requires that all reimbursements to which the IHS is entitled by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF be deposited back into CHEF.

Section 203. Health Promotion and Disease Prevention Services. This section finds that health promotion and disease prevention activities improve health and well-being and reduce the expenses for health care, and requires the Secretary to provide these services and with input from the affected Tribal Health Programs to report to Congress on the status, capacity and resources needed to promote health and prevent disease.

Section 204. Diabetes Prevention, Treatment, and Control. Section 204 requires the Secretary to determine the incidence of diabetes and its complications among Indians and the measures needed to prevent, treat and control it. The Secretary is also required, when medically indicated and with informed consent, to screen Indians for diabetes and for conditions which indicate a high risk for diabetes.

The Secretary is required to continue to fund model diabetes projects and dialysis programs. To the extent that funding is available, the Secretary is required to work with each Area Office to consult with tribes and tribal organizations regarding diabetes programs; establish registries in Area Offices; and ensure that data collected are disseminated to other Area Offices, subject to privacy laws.

Section 205. Shared Services for Long-Term Care. This section authorizes the Secretary to enter funding agreements for delivering

long-term care services to Indians. Contents of these funding agreements are specified. Any nursing facility funded under this section must meet the requirements for such facilities under section 1919 of the Social Security Act. In addition, the Secretary is required to provide necessary technical and other assistance to enable applicants to comply with the provisions of this section. The Secretary is required to encourage the use of existing underused facilities or allow the use of swing beds for long-term or similar care.

Section 206. Health Services Research. The Secretary is required to provide funding for both clinical and nonclinical research to further the delivery of Indian health services and shall coordinate the activities of other agencies within the Department to address this need. Tribal Health Programs are to be given equal opportunity to compete for these research funds.

Section 207. Mammography and Other Cancer Screening. This section requires the Secretary, either through the IHS or Indian tribes, to provide for mammography and other cancer screening consistent with appropriate standards. This section does not establish a standard itself, but requires an appropriate standard be established which is consistent with Title XVIII of the Social Security Act.

Section 208. Patient Travel Costs. Section 208 requires the Secretary to provide funds for the travel costs of patients and their appropriate and necessary qualified escorts, associated with receiving health care services.

Section 209. Epidemiology Centers. This section requires the Secretary, within 180 days of enactment, to establish and fund epidemiology centers in each Service Area without reducing the funding levels for centers already established.

Newly established centers may be operated by Tribal Health Programs. The functions of these centers are delineated in this section. The Director of the Centers for Disease Control and Prevention is required to provide technical assistance to the centers and the Secretary is authorized to provide funding to tribes, tribal organizations and urban Indian organizations to conduct epidemiological studies of Indian communities.

Section 210. Comprehensive School Health Education Programs. Section 210 requires the Secretary to provide funding to Indian tribes, tribal organizations and urban Indian organizations, for the development of comprehensive school health education programs for children from pre-school through grade 12. The specific purposes for which funds may be used are delineated.

Upon request, the Secretary is required to provide technical assistance in the development and dissemination of comprehensive health education plans, materials and information. The Secretary, through the IHS and in consultation with tribes, tribal organizations and urban Indian organizations, shall establish criteria for review and approval of applications for this funding.

Section 211. Indian Youth Program. This section authorizes the Secretary to establish and administer programs for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and Urban Indian preadolescent and adolescent youths. Allowable and prohibited uses of the funds authorized are delineated.

The Secretary is required to disseminate information regarding models for delivery of comprehensive health care services to Indian Youth; to encourage the implementation of these models; and provide technical assistance upon request. The Secretary is to establish criteria for review and approval of applications under this section, in consultation with tribes, tribal organizations and urban indian organizations.

Section 212. Prevention, Control, and Elimination of Communicable and Infectious Diseases. Section 212 authorizes the Secretary to fund projects specifically for the purpose of preventing, controlling and eliminating communicable and infectious diseases. Funding is also authorized for public information and education programs, and skills improvement activities.

Demonstration projects for the screening, treatment and prevention of hepatitis C virus are also authorized. Funding under this section requires an application or proposal for funding. Entities which receive funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention as well as State and local health agencies.

Finally, in carrying out this section, the Secretary may provide technical assistance upon request and shall submit a biennial report to Congress on the use of the funds and the progress made toward prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

Section 213. Authority for Provision of Other Services. This section authorizes the Secretary to fund other activities which meet the objectives set forth in section 3 of this Act. A partial list of such activities include: hospice care; assisted living; long-term health care; home- and community-based services; public health functions; and, Traditional Health Care Practices.

Current law authorizes a feasibility study to be conducted on these facilities. However, the IHS never completed that study and now twelve years later, to conduct such studies would greatly delay needed services. The Committee is concerned about prohibiting these services from the Indian health care system when these types of services have become an accepted part of the national health care system and Medicare since 1983.

Discretion is provided to the IHS, Indian Tribes, or Tribal Organizations to provide such care to persons otherwise ineligible for the health care benefits of the IHS (subject to reimbursement of reasonable charges). The inclusion of these individuals is necessary to achieve the minimum patient base needed to make the venture financially viable and to stabilize the cost efficiencies of providing these services.

Currently, these types of services are not readily available to Native communities. Indians must travel long distances only to be placed in facilities which are not familiar and not conducive to their well-being as the facilities are not culturally-competent. Having culturally-competent facilities close to Indian communities will promote the patient's well-being and enable family members to visit without extraordinary cost.

Section 214. Indian Women's Health Care. This section requires the Secretary to provide funds to monitor and improve health care for Indian women of all ages. The Committee believes the health of Indian women to be vitally important and encourages the IHS

to heighten attention to addressing diseases disproportionately affecting Indian women such as lupus.

Section 215. Environmental and Nuclear Health Hazards. Section 215 requires the Secretary, in conjunction with other Federal agencies, to conduct studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and other Indians as a result of environmental hazards, such as nuclear resource development, petroleum contamination, and contamination of water sources and of the food chain.

Upon completion of such studies the Secretary shall develop health plans to address the health problems studied. The Secretary is required to submit the study to Congress within 18 months of enactment and a report no later than 1 year after the study which includes recommendations for the implementation of the plan and evaluation activities.

This section establishes an intergovernmental task force to identify environmental hazards and to take corrective action. The Secretary is to chair this task force, which shall meet at least twice yearly. If an Indian, who is employed in or around any environmental hazard, suffers from a work-related condition, the Indian Health Program which treats him, may be reimbursed by the Indian's employer.

Section 216. Arizona as a Contract Health Service Delivery Area. The State of Arizona is designated as a contract health service delivery area for providing contract health care services to members of Federally-recognized Indian Tribes of Arizona. The IHS will not curtail any services as a result of this provision.

These contract health service delivery areas under sections 216 to 218 have been authorized, but in some cases not implemented or funded. The Committee encourages the Administration to seek funding for these programs. The provisions are subject to appropriations as all discretionary programs are, and does not subject the Secretary to retroactive liability or application.

Section 216A. North Dakota as a Contract Health Service Delivery Area. The State of North Dakota is designated as a contract health service delivery area for providing contract health care services to members of Federally-recognized Indian Tribes of Arizona. The IHS will not curtail any services as a result of this provision.

Section 216B. South Dakota as a Contract Health Service Delivery Area. The State of South Dakota is designated as a contract health service delivery area for providing contract health care services to members of Federally-recognized Indian Tribes of Arizona. The IHS will not curtail any services as a result of this provision.

Section 217. California Contract Health Services Program. This section appoints the California Rural Indian Health Board (CRIHB) to be a contract care intermediary to improve the accessibility of health services to California Indians. The Secretary is required to reimburse CRIHB for costs incurred pursuant to this section.

Not more than 5 percent of the amounts provided under this section may be for administrative expenses. No payment may be made for treatment under this section to the extent payment may be made under the Indian Catastrophic Health Emergency Fund or from amounts appropriated or otherwise made available to the California contract health service delivery area.

This section also establishes an Advisory Board, comprised of representatives from not less than 8 Tribal Health Programs serving California Indians covered under this section and at least one half of whom are not affiliated with the CRIHB. The Advisory Board will advise the CRIHB in carrying out this section.

Section 218. California as a Contract Health Service Delivery Area. The State of California, excluding certain specified counties, is designated as a contract health service delivery area for providing contract health care services to California Indians. The excluded counties may be included only if finding is specifically provided by the IHS for those counties.

Section 219. Contract Health Services for the Trenton Service Area. This section directs the Secretary to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in North Dakota and the counties of Richland, Roosevelt, and Sheridan in Montana. This section does not expand the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the IHS beyond the scope of eligibility for these services that applied on May 1, 1986.

Section 220. Programs Operated by Indian Tribes and Tribal Organizations. This section requires the IHS to provide funds to Tribal Health Programs for health care programs and facilities on the same basis as funds are provided to these programs operated directly by the IHS.

Section 221. Licensing or Certification. Section 221 requires that health care professionals employed by a Tribal Health Program, if licensed or certified in any State, be exempt from the licensing or certification requirements of the State in which the Tribal Health Program provides the services. This provision extends similar current authority for the IHS to tribal health programs. However, all health professionals must still practice within their authorized scope of practice.

Section 222. Notification of Provision of Emergency Contract Health Services. This section allows 30 days (as a condition of payment) for an elderly or disabled Indian to notify the IHS of any emergency care or health services received from a non-IHS provider or in a non-IHS facility.

Section 223. Prompt Action on Payment of Claims. Section 223 provides a deadline for the IHS to respond to notification of a claim by a provider of a contract care service. The section also provides that if the IHS fails to respond within the required time, the IHS shall accept the claim as valid. A deadline for payment is also provided. This timeframe is consistent with the Prompt Payment Act which requires the Federal government to pay its claims within 30 days.

Section 224. Liability for Payment. This section provides that a patient who receives authorized contract health care services will not be held liable for any charges or costs associated with those authorized services. The Secretary is required to notify the provider of such services and the patient who receives them of the same, within a specified time. Following receipt of this notice or an acceptable claim under the previous section, a provider has no further recourse against the patient who received the health care.

Section 225. Authorization of Appropriations. This section authorizes appropriations as are necessary to carry out this title for each fiscal year through 2015.

TITLE III—FACILITIES

Section 301. Consultation; Construction and Renovation of Facilities; Reports. This section requires consultation with Indian tribes prior to expending construction funds. In addition, it sets forth requirements to be met prior to closing any facility. This section also establishes and defines criteria for the health care facilities priority system, including reporting requirements. The responsibility for developing the initial comprehensive needs report lies with the GAO to ensure that it will get completed. The IHS is then charged with the responsibility to update the list as facility construction is completed.

Section 302. Sanitation Facilities. This section provides the findings, certain duties for sanitation, authorized uses of sanitation funding and facilities, reporting requirements and establishes the deficiency levels for those facilities. Congress has determined that sanitation is a health issue and in 1957 placed the responsibility for sanitation in Indian communities with the IHS.

This section prohibits IHS funding from being used for sanitation facilities for new DHUD homes as DHUD provides funding for such infrastructure. The IHS funds are limited and the backlog, estimated in the billions, so great that such funds cannot be diverted to the DHUD Native American Housing Assistance and Self-Determination Act block grant without a thorough examination of how to balance all the needs associated with the sanitation facilities. The Committee believes that appropriate flexibility is afforded to the Indian tribes for sanitation funding, demonstrated by the fact that over 70% of the sanitation funding is contracted by Indian tribes pursuant to the ISDEAA.

Section 303. Preference to Indians and Indian Firms. This section authorizes the Secretary to apply Indian preference in hiring for certain construction activities.

Section 304. Expenditure of Nonservice Funds for Renovation. This section authorizes the Secretary to accept any expansion or renovation funded with non-IHS funds in accordance with certain criteria.

Section 305. Funding for the Construction, Expansion and Modernization of Small Ambulatory Care Facilities. This section establishes criteria for small ambulatory care facilities, including use of funds, priorities and peer review panels. Debt reduction has also been included as an authorized use of funds within to the Secretary's discretion.

Section 306. Indian Health Care Delivery Demonstration Project. This section authorizes the Secretary to establish demonstration projects to test alternative health care delivery systems through such methods as hospice care and establishes criteria for the projects. The Committee has been made aware that the Secretary has not promulgated regulations for these projects even though required since 1991. Incentives have been added to encourage the Secretary to issue these regulations.

Section 307. Land Transfer. This section authorizes the Secretary to accept any land transferred from the Bureau of Indian Affairs for the purpose of providing health care.

Section 308. Leases, Contracts and Other Agreements. This section authorizes the Secretary to enter leases with Indian tribes and to consider them operating leases. Federal appropriations law requires that all leases be considered capital leases unless Congress otherwise designates. This provision provides that specific authority by designating the leases as operating leases, but gives the Secretary flexibility to also designate them as capital leases.

Section 309. Study for Loans, Loan Guarantees and Loan Repayment. This section authorizes a study for the feasibility of establishing a loan or loan guarantee fund for Indian health care facilities. Initially, this provision established a fund, but was reduced to a study due to the objection by the Administration. The fund was alleged to (1) disrupt the construction priority system; (2) be inconsistent with the Credit Reform Act; and (3) be inconsistent with standard Federal investment policy. Consequently, the study replaced the fund whereby those concerns could be analyzed, among other matters. The Committee strongly encourages this study be completed as quickly as possible so that additional financing options can be made available to Indian tribes.

Section 310. Tribal Leasing. This section authorizes permanent leasing of permanent structures for health services without prior approval.

Section 311. Indian Health Service/Tribal Facilities Joint Venture Program. This section authorizes the Secretary to enter joint ventures with Indian tribes, provide staffing, equipment and supplies for the operation of the facility under a no-cost lease with the Indian tribes, in accordance with certain criteria.

A new provision has been added to authorize those Indian tribes that have started, but not completed construction, be eligible to apply for joint ventures. Indian tribes should not be penalized for attempting to address their facility needs rather than wait interminably for the IHS to provide funding.

This new provision is not, however, authorization to circumvent appropriate IHS planning and construction guidelines. Balancing the criteria and priorities for those Indian tribes that are able to start construction and those that cannot and must continue to wait are appropriate items for negotiated rule-making.

Section 312. Location of Facilities. This section sets forth certain priorities in locating health care facilities to address the economically depressed native communities.

Section 313. Maintenance and Improvement of Health Care Facilities. This section requires reporting of backlogs in maintenance and improvements for facilities.

Section 314. Tribal Management of Federally-Owned Quarters. This section authorizes the Indian tribes operating a health care facility and Federally-owned quarters pursuant to a "638" contract or compact to establish reasonable rental rates for the Federally-owned quarters and directly collect the rent payments from the employee. It allows Indian tribes to take into account the reasonable value of the quarters and the amount needed to sustain them. By authorizing direct collection, cumbersome bureaucracy is eliminated.

This provision complements the quarters provisions under the ISDEAA, section 105, which directs how rental rates are established, but does not take into account appropriate fair market values including location costs, nor does it allow direct collection of rents.

Section 315. Applicability of Buy American Act Requirement. This section requires application of the Buy American Act for all procurement except purchases by Indian tribes or tribal organizations under this Act.

Section 316. Other Funding for Facilities. This section authorizes the Secretary to accept funding from other sources for the construction of health care facilities and may transfer such funds to Indian tribes.

Section 317. Authorization of Appropriations. This section authorizes appropriations through fiscal year 2015.

TITLE IV—ACCESS TO HEALTH SERVICES

Section 401. Treatment of Payments Under Social Security Act Health Care Programs. This section requires that any Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) payments received by an Indian Health Program or Urban Indian Organization shall not be considered in determining appropriations for health care services. Indians who are covered under these programs will not be given preferential treatment over those Indians who are not covered by Medicare, Medicaid, or SCHIP. Specifications are made as to how funds collected from Medicare, Medicaid, or SCHIP are to be used. Finally, this section authorizes Tribal Health Programs to directly bill and receive payment from Medicare, Medicaid, SCHIP, or third party payors.

Section 402. Grants to and Funding Agreements with the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations. This section requires the Secretary to make grants or other funding agreements with tribes and tribal organizations. In doing so, the Secretary shall place conditions as deemed necessary to effect the purpose of such funding. Additional agreements may be made in order to improve the enrollment of Indians under Social Security Act programs and to facilitate cooperation with and agreements between States, the IHS, Indian Tribes, Tribal Organizations, or Urban Indian Organizations. Specifications for applying this section to Urban Indian Organizations is included in this section. This section also codifies certain requirements contained in current regulations for agreement with states for outreach.

Section 403. Reimbursement From Certain Third Parties of Costs of Health Services. Section 403 continues recovery rights established since 1988. It authorizes recovery from third parties for health services provided to the same extent that an individual, or any nongovernmental provider of health services, would be eligible to receive damages, reimbursement, or indemnification.

Certain State or local laws are deemed nonapplicable to prevent or hinder this right of recovery. This section has no effect on private rights of action. Enforcement measures, limitations, costs and attorneys' fees are also specified.

Other items covered in this section are nonapplication of claims filing requirements; application to urban Indian organizations; statute of limitations; and a savings clause.

While this provision does not create a cause of action within tribal courts, it does allow the parties more options for their choice of law provisions in their contracts. It also complements ERISA provisions which may apply state law. It also does not conflict with ERISA as, under ERISA, jurisdiction is exclusive in Federal courts for most causes of action and concurrent for the remaining causes of action, with a right of removal from state court to Federal court.

Section 404. Crediting of Reimbursements. This section specifies the use of amounts collected and disallows any offset or limit of amount obligated from the IHS because of the receipt of reimbursements under this section.

Section 405. Purchasing Health Care Coverage. Section 405 authorizes funding to be used for purchasing health insurance or used for a self-insurance plan providing coverage to Indians.

The purpose of this section is to authorize the purchase of insurance through various means instead of, or in addition to, establishing health programs, hospitals, clinics, etc., if it is a more cost-beneficial means of addressing Indian health care needs.

The purchasers must be mindful of applicable Federal or state insurance laws which may affect the purchase or coverage for the tribal members. However, the Committee is aware that Indian tribes may have many tribal members living in different states and should not be prohibited from providing health care through insurance coverage.

This provision authorizes funding to be used to support a tribal self-insured plan. The Committee is aware that a tribal self-insured plan may include non-eligible beneficiaries who are tribal employees.

The Committee does not wish to discourage Indian tribes from hiring individuals deemed to be non-eligible beneficiaries under the Act and providing them with benefits, particularly the health employees. In fact, the salaries and benefits for tribal health employees is already part of the Federal funding system, although, arguably, in their capacity as tribal health employees, these individuals are not necessarily "beneficiaries" eligible or otherwise.

Section 406. Sharing Arrangements with Federal Agencies. Within certain limitations this section authorizes the Secretary to share medical facilities and services with the Departments of Veterans Affairs and Defense. If health care services are provided to beneficiaries eligible for services from either the Department of Veterans Affairs or the Department of Defense, then the IHS, Indian Tribe, or Tribal Organization providing the service shall be reimbursed from the appropriate Department.

Section 407. Payor of Last Resort. This section specifies that Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to eligible persons.

Section 408. Nondiscrimination in Qualifications for Reimbursement for Services. Section 408 requires entities that are operated by the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization to be licensed or recognized under State or local law to furnish such services, for purposes of receiving payment or reimbursement from any Federally-funded health care program. This provision should not be interpreted as establishing a payment

methodology, but rather it is criteria to apply in determining whether the provider is eligible for payment.

Section 409. Consultation. This section establishes a National Indian Technical Advisory Group to assist the Secretary in identifying and addressing issues regarding health care programs under the Social Security Act. This Group is critical in identifying and resolving issues and barriers to access for Indians.

Thus, it is necessary that the Urban Indian organizations and the IHS be a part of this Group as they serve a majority of the Indian beneficiaries. The Group would not be effective without these two entities.

Section 410. State Children's Health Insurance Program (SCHIP). This section authorizes the Secretary to arrange with individual States to allow SCHIP funds for Indians to be provided to the IHS, Indian Tribe, or Tribal Organization for providing assistance to such individuals consistent with the purposes of SCHIP.

The Committee is deeply concerned that Indian children are not being served even though the Balanced Budget Act of 1997 specifically mandated that States include provisions in their plan explaining how Indian children would be served. Briefings before the Committee revealed that the DHHS could not determine the number of eligible Indian children nor how many were actually served.

The Committee believes the Administration is committed to correcting this issue and has undertaken great efforts to find solutions. The Committee believes that Indian tribes could provide significant assistance in these efforts, particularly in outreach and enrollment.

Section 411. Social Security Act Sanctions. This section authorizes Indian Health Programs to request a waiver of a sanction imposed against a health care provider the same way that a State may request such a waiver. This provision is solely a procedural mechanism for waiver, it does not otherwise affect the Secretary's underlying authority to review and decide upon waivers.

The Committee is aware that problems have existed in seeking waivers as the Indian tribes may request the State seek the waiver and those requests have not been honored. The purpose of this provision is not to allow tribal health programs to become havens for sanctioned providers, but to address, in an appropriate manner, the enormous recruitment problems they face.

The Committee also recognizes that the State, as the Medicaid administrator, may also have an interest in commenting on the waiver request. The Committee believes the Secretary may provide the appropriate avenues for accommodating these interests.

A safe harbor clause is included in this section for transaction between and among Indian Health Care Programs. This provision will shield the referral system existing between the IHS, tribal and urban Indian organizations from criminal sanctions. The referrals exist to maintain continuity of care for Indian patients and not for monetary gain.

Section 412. Cost Sharing. This section addresses the following areas regarding cost sharing: coinsurance, copayments, and deductibles; exemption from Medicaid and SCHIP premiums; limitation on medical child support recovery; treatment of certain property for Medicaid eligibility; and, continuation of current law protections of certain Indian property from Medicaid estate recovery.

The medical child support recovery provisions include Indian health programs, not just the IHS. Currently, the Department's policy on the Medical Support Enforcement for Tribal Members may not cover these additional programs and this provision is designed to clarify the coverage.

The treatment of certain property for Medicaid eligibility provision governs the various types of Indian property to be excluded when determining eligibility. This provision should be given the broadest possible interpretation as Congressional policy has provided extensive protections for various types of Indian property and taking into account that the purpose of these provisions is to increase enrollment, not to find ways to exclude Indians from coverage.

Section 413. Treatment under Medicaid Managed Care. Section 413 specifies actions to be taken for payment for services furnished to Indians in Medicaid managed care programs. This section also allows Medicaid managed care programs to be offered and gives parameters for such.

In section 413(b), a State that operates its Medicaid program through managed care organizations or primary care case managers, is authorized to enter into an agreement with an Indian health program or consortium of such programs that intend to operate as an MCO or primary care case manager for its Indian patients. The Indian health program must still meet the State's quality standards, but the State and the Secretary are authorized to waive requirements such as enrollment and capitalization as needed to facilitate the participation of the Indian health programs.

This provision is not intended to change the Secretary's underlying waiver authority or any standards governing such waivers. It merely provides the Secretary authority to waive taking into account the special circumstances within the Indian health system.

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

Section 415. Authorization of Appropriations. Section 415 authorizes appropriations of such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Section 501. Purpose. This section sets forth the purpose of the title which is to maintain urban Indian health programs to make health services available to urban Indians.

Section 502. Contracts with, and Grants to, Urban Indian Organizations. This section sets forth the authority of the Secretary to enter contracts with or make grants to urban Indian organizations.

Section 503. Contracts and Grants for the Provision of Health Care and Referral Services. This section sets forth the standards, criteria and uses of funds for contracts and grants for health care services.

Section 504. Contracts and Grants for the Determination of Unmet Health Care Needs. This section sets forth the standards, criteria and uses of funds for contracts and grants to determine unmet health care needs of urban Indians.

Section 505. Evaluations; renewals. This section authorizes the Secretary to develop evaluation and renewal standards for the various contracts and grants.

Section 506. Other contract and grant requirements. This section sets forth other specific contract and grant requirements such as payment methods, procurement and amendments.

Section 507. Reports and Records. This section sets forth certain reporting and recordkeeping requirements for urban Indian organizations.

Section 508. Limitation on Contract Authority. This section limits contracts to the amount of appropriations.

Section 509. Facilities. This section sets forth the various requirements governing the funding for urban health care facilities.

Section 510. Office of Urban Indian Health. This section establishes an Office of Urban Indian Health within the IHS.

Section 511. Grants for Alcohol and Substance Abuse Related Services. This section establishes criteria for alcohol and substance abuse grants.

Section 512. Treatment of Certain Demonstration Projects. This section makes permanent certain demonstration projects in Oklahoma.

Section 513. Urban NIAAA Transferred Programs. This section authorizes the Secretary to transfer to urban Indian organizations alcohol programs that had been previously transferred to the Secretary.

Section 514. Consultation. This section establishes consultation requirements with Urban Indian Organizations.

Section 515. Federal Tort Claim Act Coverage. This section authorizes the urban Indian organizations to be deemed an executive agency for FTCA coverage.

Section 516. Urban Youth Treatment Center Demonstration. This section authorizes the Secretary to fund at least 2 Indian youth treatment centers in certain states where urban centers are located.

Section 517. Use of Federal Property and Supply. This section authorizes the Urban Indian Organizations to receive donations of Federal excess property and access the Federal sources of supply through 40 U.S.C. 501.

Section 518. Grants for Diabetes Prevention, Treatment and Control. This section sets forth requirements and criteria for diabetes grants.

Section 519. Community Health Representatives. This section authorizes contracting for community health representatives.

Section 520. Regulations. This section authorizes the promulgation of regulations for this title.

Section 521. Eligibility for Services. This section establishes the beneficiaries of the services under this title.

Section 522. Authorization of Appropriations. This section authorizes appropriations through fiscal year 2015.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Section 601. Establishment of the Indian Health Service as an Agency of the Public Health Service. Section 601 elevates the position of Director of the Indian Health Service to Assistant Secretary of Indian Health; and specifies the duties and responsibilities of the

Assistant Secretary and deems that any reference to the Director of the Indian Health Service in any Federal law, Executive order, rule, regulation, or delegation of authority, etc., refer to the Assistant Secretary.

Section 602. Automated Management Information System. Section 602 requires the Secretary to establish an automated management information system for the IHS and each Tribal Health Program. It requires that patients have access to their own health records. It authorizes the Secretary to enter contracts, agreements, or joint ventures for the purpose of enhancing information technology in Indian health programs and facilities.

Section 603. Authorization of Appropriations. This section authorizes appropriated funds in sums that may be necessary to carry out this title, for each fiscal year through fiscal year 2015.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

Section 701. Behavioral Health Prevention and Treatment Services. Section 701 states the purposes of the section; requires the Secretary to encourage the development of plans for delivery of Indian Behavioral Health Services; directs the Secretary to establish a national clearinghouse of plans and reports of outcomes; directs the Secretary to provide comprehensive behavioral health care programs; facilitates the governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization to establish community behavioral health plans; requires the Secretary to coordinate behavioral health planning; and, directs the Secretary to assess the need, availability and cost for inpatient mental health care for Indians.

Section 702. Memoranda of Agreement with the Department of the Interior. This section requires the Secretary to develop and enter, or review and update, memoranda of agreement with the Secretary of the Interior to, among other things, make a comprehensive assessment, coordination, and annual review of all the behavioral health care needs and services available or unavailable to Indians. Specific provisions that are required in this memoranda are delineated. Consultation requirements for the Secretary are specified. Each memorandum of agreement under this section shall be published in the Federal Register.

Section 703. Comprehensive Behavioral Health Prevention and Treatment Program. Section 703 requires the Secretary to provide a program of comprehensive behavioral health, prevention, treatment, and aftercare. The Secretary may provide these services through Contract Health Services.

Section 704. Mental Health Technician Program. This section establishes a mental health technician program within the Service, requiring high-standard paraprofessional training in mental health care, supervision and evaluation of technicians. This program shall involve use and promotion of Traditional Health Care Practices of the Indian Tribes to be served.

Section 705. Licensing Requirement for Mental Health Care Workers. This section requires that any person employed as a psychologist, social worker, or marriage and family therapist, be licensed to provide those services, but does not automatically license the professionals.

Section 706. Indian Women Treatment Programs. Consistent with section 701, this section requires that funds be made available to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services, specifically addressing the spiritual, cultural, historical, social, and child care needs of Indian women.

Section 707. Indian Youth Program. Consistent with section 701, this section requires the development and implementation of a program for detoxification and rehabilitation of Indian Youth. It also establishes alcohol and substance abuse treatment centers or facilities for Indian youth. Additional provisions addressed in this section are: intermediate adolescent behavioral health services; use of Federally-owned structures; rehabilitation and aftercare services; inclusion of family in youth treatment programs; and multi-drug abuse programs.

Section 708. Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing. This section authorizes the Secretary to provide inpatient mental health care facilities in each Service Area.

Section 709. Training and Community Education. Section 709 requires that the Secretary, in cooperation with the Secretary of the Interior, to provide either directly or through funding, a program of community education in the area of behavioral health. Specifics of instruction are delineated. This section also requires the Secretary to develop and provide community-based training models.

Section 710. Behavioral Health Program. This section authorizes the development of innovative community-based behavioral health programs; suggests criteria to be used for funding such programs; and, requires that the same criteria as used in evaluating other funding proposals be used for programs under this section.

Section 711. Fetal Alcohol Disorder Funding. Section 711 establishes fetal alcohol disorder programs, to include the development and provision of services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities. In addition a Fetal Alcohol Disorder Task Force is established to advise the Secretary. Funding is to be made available for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat or provide rehabilitation and aftercare for Indians affected by this disorder. Urban Indians are to be included in these programs.

Section 712. Child Sexual Abuse and Prevention Treatment Programs. This section establishes Child Sexual Abuse and Prevention Treatment Programs for both the victims and perpetrators of this abuse in Indian households or who are Indian. The allowable uses of funds for these programs are specified.

Section 713. Behavioral Health Research. Section 713 provides for funding for research on the incidence and prevalence of behavioral health problems among Indians. Research priorities are specified.

Section 714. Definitions. This section provides definitions for the following terms used in this title: assessment; alcohol-related neurodevelopmental disorders or ARND; behavioral health aftercare; dual diagnosis; fetal alcohol disorders; fetal alcohol syndrome or FAS; partial FAS; rehabilitation; and substance abuse.

Section 715. Authorization of Appropriations. This section authorizes such sums as may be necessary to carry out this section, for each fiscal year through fiscal year 2015.

TITLE VIII—MISCELLANEOUS

Section 801. Reports. This section outlines the various reporting requirements under this Act.

Section 802. Regulations. This section sets forth the various requirements for regulations, including negotiated rule-making, under this Act.

Section 803. Plan of Implementation. This section requires a plan of implementation of this Act to be submitted to Congress.

Section 804. Availability of Funds. This section authorizes funding to remain available until expended.

Section 805. Limitation on Use of Funds Appropriated to the IHS. This section establishes certain limitations on the use of funds.

Section 806. Eligibility of California Indians. This section clarifies the eligibility for the Indians located in California.

Section 807. Health Services for Ineligible Persons. This section authorizes services for certain ineligible persons under limited circumstances and outlines criteria for providing services.

Section 808. Reallocation of Base Services. This section limits the reallocation of base funding upon certain requirements the Secretary must fulfill.

Section 809. Results of Demonstration Projects. This section requires that results of demonstration projects be made available to Indian tribes.

Section 810. Provision of Services in Montana. This section recognizes a court decision governing services for certain Indians in Montana whereby the IHS is responsible for making payment for Indians' health care expenses when other funds have been exhausted and are not available. *McNabb* v. *Bowen,* 829 F.2d 787 (9th Cir. 1987).

Section 811. Moratorium. This section authorizes the IHS to provide certain services according to eligibility criteria in effect on a certain date.

Section 812. Tribal Employment. This section recognizes the governmental purposes of health care by treating Indian tribes or tribal organizations not as an employer for certain purposes.

Section 813. Prime Vendor. This section recognizes tribal health programs as an executive agency for accessing the Federal sources of supply and streamlines access. This provision authorizes direct access for Indian tribes to the sources of supply rather than accessing through the IHS.

Section 814. Severability Provisions. This section retains remaining provisions if others are stricken by any court.

Section 815. Establishment of National Bipartisan Commission on Indian Health Care Entitlement. This section establishes a commission to study Indian health care as an entitlement, including duties, membership and reports. This Commission is to collect data on the extent of Indian health care needs, including conducting hearings, studying models for providing health care. After the study, the Commission is to make recommendations for legislation providing for Indian health care as an entitlement, including eligi-

bility, benefits, costs, and impact on the current Indian health care system. The Commission consists of 25 members, including Members of Congress and Indian tribes.

Section 816. Appropriations; Availability. This section subjects new spending to the availability of funding.

Section 817. Confidentiality of Medical Quality Assurance Records: Qualified Immunity for Participants. This section establishes requirements for quality assurance such as confidentiality, privacy, disclosure and liability and sets forth the limits on such disclosure to promote the free exchange of information and recommendations from the health professionals and employees.

Section 818. Authorization of Appropriations. This section authorizes appropriations through fiscal year 2015.

OTHER SECTIONS OF THE BILL

Section 2(b) and (c). Section 2(b) and (c) of the bill sets forth provisions of the bill amending other laws such as the references to the "Director of Indian Health Service" which would be changed to "Assistant Secretary for Indian Health"; and amendments to the Three Affiliated Tribes and Standing Rock Sioux Tribe Equitable Compensation Act which authorizes funding to rebuild a health care facility.

Section 3. Section 3 of the bill retains authorization for sanitation facilities to the Soboba Band of Mission Indians.

Section 4. Section 4 of the bill sets forth amendments to the Medicaid and SCHIP which authorize reimbursement to Indian health programs for medical assistance provided.

COST AND BUDGETARY CONSIDERATIONS

Due to time constraints, the cost estimate for S. 556 is not included in this Report. When it is received by the Committee, the cost estimate will be included in the Congressional Record.

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 556 will have minimal regulatory or paperwork impact.

EXECUTIVE COMMUNICATIONS

The Committee received oral and written testimony from the U.S. Department of Health and Human Services at the hearing on S. 556 held on April 2, 2003, July 16, 2003 and July 21, 2004. The Committee received oral and written testimony from the U.S. Department of Housing and Urban Development at the hearing on S. 556 held on July 16, 2003. The written testimony is attached as follows:

STATEMENT OF CHARLES W. GRIM, D.D.S., M.H.S.A, INTERIM DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Michel Lincoln, Deputy Director, Mr. Gary Hartz, Acting Director of the Office of Public Health, and Dr. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Office of Public Health. We are pleased to have this opportunity to testify on behalf of Secretary Thompson on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003". And, at the Committee's request, I will report on the Secretary's One-Department Initiative as it impacts the IHS and the president's FY 04 budget proposal to consolidate automated information systems in the Department.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally-recognized American Indians and Alaska Natives (AI/ANs) through a system of IHSA, tribal and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal government obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives (AI/ANs): The Snyder Act of 1921, P.L. 67–85, and the Indian Health Care Improvement Act (IHCIA), Public Law 94–437. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indian/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provided the authority for the programs of the Federal government that deliver health services to Indian people, but the IHCIA also provided additional guidance in several areas. The IHCIA contained specific language that addressed the recruitment and retention of a number of health professionals serving Indian communities focused on health services for urban Indian people and addressed the construction, replacement, and repair of health care facilities.

We are here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. S. 556 reflects the product of an extensive tribal consultation process that took

two full years and resulted in a tribally drafted reauthorization bill. IHS staff provided technical assistance and support to the Indian tribes and urban Indian health programs through this lengthy consultation.

The Department supports the purposes of S. 556 to improve the health status of AI/AN people and to raise health status the highest possible level. We do, however, continue to have concerns, as expressed previously to the Committee in the Secretary's September 27, 2001 report on S. 212, regarding a number of provisions in that bill. As introduced, S. 556 is identical to S. 212. There are several provisions in S. 556 that are inconsistent with current Medicare and Medicaid provider payment practices and could inappropriately increase costs. For example:

• Title II, Section 202, which describe a new provider type called a Qualified Indian Health Provider (QIHP) and Sections 212 and 221 regarding extension of the 100% Federal matching rate for Medicaid and SCHIP. These sections are further discussed below in the statement.

• In addition, Section 419 proposes to exempt patients eligible for Medicare or Medicaid from standard cost-sharing requirements such as deductibles, co-payments, and premiums. We have no concern with the current exception for Indian children exempt from premiums and co-pays in the SCHIP program.

The Department also reported in the staff analysis of its September 27, 2001 bill report some concerns with the managed care provisions in Section 423 which limits appropriate cost and utilization incentives in Medicare and Medicaid by potentially undermining capitated payments in managed care settings.

The Administration is seriously concerned about these provisions, which undermine standard practices in Medicare and Medicaid. The most pressing concerns were outlined in the Secretary's September report which I will present to you today: (1) the Qualified Indian Health Program (QIHP); (2) negotiated rule making; and (3) extension of 100% Federal matching rate for Medicaid and SCHIP.

While the Administration continues to have serious concerns about S. 556 in its current form, we are committed to working with the Committee on legislation to reauthorize this important cornerstore authority for the provision of health care to American Indians and Alaska Natives.

QUALIFIED INDIAN HEALTH PROGRAM (QIHP)

The bill would amend the Medicare statute to add various detailed provisions for a new provider type called a Qualified Indian Health Provider (QIHP) for IHS, Tribal, and urban Indian (I/T/U) providers participating in the Medicare and Medicaid programs. The most problematic aspects of QIHP are the structure and operation of the payment provisions, which are not only burdensome but, more importantly, would not be feasible to administer. QIHP would require the Federal government to complete

a series of complex payment computations for each I/T/U provider, for each payment period, (including rates and adjustments not available to any other provider) to identify the provider type for each that yields the highest payment amount for that period. However, such computations could only be made after services are provided, when it is too late for the providers to have known or complied with the differing conditions of participation applicable to differing provider types. In addition to the burden and feasibility issues, on a more fundamental level, this "full cost plus other costs" QIHP payment approach would be contrary to the way that Medicare generally pays providers. Moreover, it would impose disproportionately higher costs on a program that is approaching insolvency. Extending such a payment approach to Medicaid and SCHIP would raise similarly serious administrative and budgetary concerns.

NEGOTIATED RULE MAKING; TRIBAL CONSULTATION; ADMINISTRATIVE BURDENS

We are concerned that S. 556 would appear to broadly mandate use of negotiated rule making to develop all regulations to implement the IHCIA. Negotiated rule making is very resource-intensive for both Federal and non-Federal participants. It can be effective in appropriate circumstances, but may not be the most effective way to obtain necessary Indian provider input in the development of IHCIA rules and regulations in a given case.

Additionally, while we appreciate the value of consultation with Tribes, we have concerns about the consultation requirements. The bill would require Tribal consultation prior to the Centers for Medicare & Medicaid Services (CMS) adopting any policy or regulation, as well as require all HHS agencies to consult with urban Indian organizations prior to taking any action, or approving any action of a State, that may affect such organizations or urban Indians. Such requirements appear to be broader than the existing Tribal consultation requirement and would be very difficult to administer, given the hundreds of regulations and policies potentially covered.

We have similar concerns about the considerable indirect adverse impact of S. 556's extensive reporting requirements and other administrative burdens on IHS and CMS that would divert limited resources from other activities. One example is the proposed requirement for a detailed annual report on health care facilities construction needs and the survey of facilities it would entail. As IHS programs and both IHS and CMS administrative functions are funded by capped discretionary accounts, the imposition of additional administrative duties on IHS and CMS would have the practical effect of requiring cutbacks in current activities.

EXTENSION OF 100% FEDERAL MATCHING RATE FOR MEDICAID AND SCHIP

We also are concerned that the bill would extend the 100% Federal matching rate to States for Medicaid and State Children's Health Insurance Program (SCHIP) services (currently applicable to such services provided through an IHS facility) to other services provided to American Indians and Alaska Natives, including those furnished by non-Indian health care providers. This proposed change would substantially increase Federal program and administrative costs, with no guarantee and little likelihood of any more services for Indian beneficiaries or better payments for Indian providers.

As we continue our thorough review of this far-reaching, complex legislation, we may have further comments. However, we wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committee, the National Tribal Steering Committee, and other representatives of the American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

ONE-DEPARTMENT INITIATIVE

In addition to our expressed concerns with S. 556, I will now present an explanation of the Secretary's One-Department initiative and its benefit to the IHS.

The Secretary's One Department Initiative has been of great benefit to the IHS as well as the Native American constituents of the Department. The fundamental premise of this initiative is that the Department of Health and Human Services must speak with one, consistent voice. Nothing is more important to our success as a department. With regard to our tribal constituents the Secretary observed on his first trip to Indian Country that tribal programs were often "stove piped" and that there existed within HHS an assumption that the IHS had sole responsibility for the health issues facing tribes. In the two short years since the Secretary launched this initiative he has reestablished the Intradepartmental Council for Native American Affairs. The membership of this Council is comprised of the heads of all the HHS Operating and Staff Division with the IHS Director serving as the Vice-Chair. This Council serves as an advisory body to the Secretary and has the responsibility to assure that Indian policy is implemented across all Divisions. The Council provides the Secretary with policy guidance and budget formulation recommendations that span all Divisions of HHS. A profound impact of this Council on the IHS is the revised premise within HHS that all Agencies bear responsibility for the government's responsibility and obligation to the Native people of this country.

In addition to the Council the Secretary and Deputy Secretary have traveled widely to Indian Country with their

senior staff. These trips have raised the awareness of tribal issues and have contributed greatly to our capacity to speak with one voice on behalf of tribes.

An example of a tangible benefit to the IHS is the FY '04 President's budget request for IHS of $20 million for Sanitation Facilities Program. An evaluation of the program justified an increase in the FY '04 budget for the program's most needy homes. This increase was also a result of the Secretary's visit to Alaska with his senior staff in 2002. They observed the critical need for safe drinking water and sanitation facilities in Indian Country and acted decisively to increase the IHS budget request.

The One Department Initiative can be directly credited for this step forward for the Native people of this nation.

FY '04 INFORMATION TECHNOLOGY CONSOLIDATION

Also, I would like to address the Committee's request for information on the FY '04 President's budget proposal to consolidate automated information systems in the Department.

The FY '04 President's Budget for IHS includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization.

These investments will enable IHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the IT Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

The IHS budget request includes savings in the IT Budget from ongoing IT consolidation efforts and additional reduced spending through the streamlining or elimination of lower priority projects. As a result, the FY '04 IHS budget request proposed a decrease in spending for information technology below the FY '03 level of $9,282,000. This decrease is the result of IT savings associated with the creation of "one HHS" from the Department's disparate organization units and more efficient and effective management of the base HHS information technology system. Consolidation of IT resources will yield savings necessary to support program requirements.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act and other issues. We will be happy to answer any questions that you may have.

STATEMENT OF CHARLES W. GRIM, D.D.S., M.H.S.A., INTERIM DIRECTOR, INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committees:

Good morning, I am Dr. Charles Grim, Interim Director of the Indian Health Service (IHS). Today, I am accompanied by Mr. Gary Hartz, Acting Director of the Office of Public Health; Dr. Richard Olson, Acting Director, Division of Clinical and Preventive Services, Office of Public Health; and Rae Snyder, Acting Director of the Urban Health Office. We are pleased to have this opportunity to testify on behalf of Secretary Thompson on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003. And, at the Committee's request, I will discuss the health disparities, Indian health facilities and urban Indian health concerns.

The IHS has the responsibility for the delivery of health services to more than 1.6 million Federally-recognized American Indians and Alaska Natives (AI/ANs) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

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We are here today to discuss reauthorization of the IHCIA and tribal recommendations for change to the existing IHCIA in the context of the many changes that have occurred in our country's health care environment since the law was first enacted in 1976. S. 556 reflects the product of an extensive tribal consultation process that took two full years and resulted in a tribally drafted reauthor-

ization bill. IHS staff provided technical assistance and support to the Indian Tribes and urban Indian health programs through this lengthy consultation. however, we recognize that our programs overlap and have implications for other Federal agencies and their programs, and we are working with them to develop a comprehensive Administration position on this legislation.

HEALTH DISPARITIES

While the mortality rates of Indian people have improved dramatically over the past ten years, Indian people continue to experience health disparities and death rates that are significantly higher than the rest of the U.S. general population:

- Alcoholism—770% higher
- Diabetes—420% higher
- Accidents—280% higher
- Suicide—190% higher
- Homicide—210% higher

Those statistics are startling, yet they are so often repeated that some view them as insurmountable facts. But every one of them is influenced by behavior choices and lifestyle. Making significant reductions in health disparity rates, and even eliminating them, can be achieved by implementing best practices, using traditional community values, and building the local capacity to address these health issues and promote healthy choices.

A primary area of focus that I have identified based on these statistics is a renewed emphasis on health promotion and disease prevention. I believe this will be our strongest front in our ongoing battle to eliminate health disparities plaguing our people for far too long. Although we have long been an organization that emphasizes prevention, I am calling on the Agency to undertake a major revitalization of its public health efforts in health promotion and disease prevention. Both field and tribal participation in the initial stages of planning and implementation is critical.

Fortunately, the incidence and prevalence of many infectious diseases, once the leading cause of death and disability among American Indians and Alaska Natives, have dramatically decreased due to increased medical care an public health efforts that included massive vaccination and sanitation facilities construction programs. Unfortunately, as the population lives longer and adopts more of a western diet and sedentary lifestyle, chronic diseases emerge as the dominant factors in the health and longevity of the Indian population with the increasing rates of cardiovascular disease, Hepatitis C virus, and diabetes.

Cardiovascular disease is now the leading cause of mortality among Indian people, with a rising rate that is significantly higher than that of the U.S. General population. This is a health disparity rate that the President, the Secretary of Health and Human Services, and the IHS are committed to eliminating. The IHS is working with other

HHS programs, including the Centers for Disease Control and Prevention and the National Institutes of Health's National Heart Lung and Blood Institute, to develop a Native American Cardiovascular Disease Prevention Program. Also contributing to the effort is the IHS Diabetes Program, the IHS Disease Prevention Task Force, and the American Heart Association. The primary focus is on the development of more effective prevention programs for AI/AN communities. The IHS has also begun several programs to encourage employees and our tribal and urban Indian health program partners to lose weight and exercise, such as "Walk the Talk" and "Take Charge Challenge" programs.

Diabetes mortality rates have been increasing at almost epidemic proportions. American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. The incidence of type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population, and is 2.6 times the national average. As diabetes develops at younger ages, so do related complications such as blindness, amputations, and end stage renal disease. Today I want to report to you that we may be seeing a change in this pattern however. In CY 2000 we have observed for the first time ever a decline in mortality. I must note that this is preliminary mortality data that needs to be thoroughly examined.

What is most distressing however about these statistics is that type 2 diabetes is largely preventable. Lifestyle changes, such as changes in diet, exercise patterns, and weight can significantly reduce the changes of developing type 2 diabetes. Focusing on prevention not only reduces the disease burden for a suffering population, but also lessens and sometimes eliminates the need for costly treatment options. The cost-effectiveness of a preventative approach to diabetes management is an important consideration, since the cost of caring of diabetes patients is staggering. Managed care estimates for treating diabetics range from $5000–$9000 per year. Since the Indian health system currently cares for approximately 100,000 people with diagnosed diabetes, this comes out to a conservative estimate of $500 million just to treat this one condition.

Another area of concern is in behavioral health, specifically the identification and treatment of depression and strategies for prevention of depression. A recent study from Washington University in St. Louis has revealed that untreated depression doubles the risk for chronic diseases like diabetes and cardiovascular disease, not to mention the risks for alcoholism, suicide, and other violent events. This study also showed that of those individuals with chronic disease, unrecognized and untreated depression doubles the risk for complications of the chronic disease (e.g., amputations and renal disease in diabetics). We must find the best practices that will allow us to prevent depression primarily, or at the least recognize and treat it early

if we are to reduce the disparities that affect Indian communities.

In summary, preventing disease and injury is a worthwhile financial and resource investment that will result in long-term savings by reducing the need for providing acute care and expensive treatment processes. It also yields the even more important humanitarian benefit of reducing pain and suffering, and prolonging life. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect AI/AN people.

HEALTH CARE FACILITIES

Title III authorizes the Facilities programs which construct, renovate, maintain, and improve facilities where Indian health services are provided. Sanitation facilities construction is conducted in 38 States with Federal recognized Tribes where ownership of the facilities is turned over to the Tribes to operate and maintain them once completed. The IHS health care facilities program including the tribal programs, specifically, is responsible for managing and maintaining the largest inventory of real property in the Department of Health and Human Services, with over 9 million square feet (850 gross square meters) of space. There are 49 hospitals, 231 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics which support the delivery of health care to our people. These facilities authorizations put in place the foundation on which health care delivery is provided to American Indians and Alaska Natives.

Health care facilities needs assessment and report

Proposed provisions in the IHCIA reauthorization bills require IHS to report annually, after consultation with Tribes, on the needs for health care facilities construction, including the renovation and expansion needs. In fact, efforts are currently underway to develop a complete description of need similar to what would be required by the Bill. While not all the resource issues have been resolved, the process is in progress and the plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the Tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

Using sanitation facilities construction funds to serve HUD homes

Section 302(b)(3)(C) specifically proposes that IHS sanitation facilities construction funds will not be used to support service of sanitation facilities to Department of Housing and Urban Development (HUD) homes. The IHS is concerned that homes constructed using HUD funds in-

clude the necessary infrastructure to make a home complete, including safe water and sewer and wastewater disposal.

As you know, the Administration is actively reviewing S. 556 and will provide you with specific details of our analysis very shortly. We are committed to working with Tribes and other agencies to ensure that adequate facilities are planned for and funded in conjunction with new home construction, and we appreciate HUD's and other Federal agencies' willingness to work with us in this regard.

Classifying long term leases as operating leases

Proposed provisions of the bills would make it possible to classify a lease for health care space as an operating lease and allow for long term leases for space (capital leases) to be scored against the budget in the first year of the lease. The intent of the proposed section is to make it possible for Tribes to acquire a facility and enter into a long term lease with the Government without having the full cost of the lease scored against a single year's budget. While this may make it possible for Tribes to more easily acquire needed space to house health care services, there is concern that leasing capital space in this manner will commit future Congresses and Administrations to funding without the opportunity for review.

Retroactive funding of Joint Venture Construction Projects

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

Sanitation facilities deficiency definitions

Proposed new language in the bills, which provides definitions of sanitation deficiencies used to identify and prioritize water and sewer projects in Indian Country, is ambiguous. As written deficiency level III could be interpreted to mean all methods of service delivery are adequate to level III requirements (including methods where water and sewer service provided by hauling rather than through piping systems directly into the home) and only the operating condition, for example frequent service inter-

ruptions, make that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe that there should be a distinction.

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

Tribal management of federally-owned quarters

The bills reiterate authorization already provided in the Indian Self-Determination and Education Act (P.L. 93–638, as amended). We are concerned that slight differences in wording in the two bills either as written or in amendments could cause confusion. We believe that this proposed addition of unnecessary language should be deleted.

Threshold criteria for small ambulatory program

The Small Ambulatory Care Facility section contains proposed language that limits participation in the Small Ambulatory Program to facilities that provide more than 500 visits to eligible users and that provide ambulatory care in a service area with a population of more than 1,500 eligible Indians. These criteria are both lower limits and would apply to many facilities including all large health centers, most of which also qualify for priority evaluation and possible funding under Section 301 of the two bills. We are concerned that some facilities that meet these criteria may be of a lower priority than those on the Priority List submitted to Congress and could receive construction funding before higher priority construction needs. We do, however, see a need for a Small Ambulatory Program that addresses the needs of Tribes with smaller facilities that do not meet the threshold to compete for placement on the Section 301 Priority Lists. For that reason we recommend that this section set an upper threshold criterion of 4,400 primary care provider visits for participation in the Small Ambulatory Program. The lower limit should be 500 primary care provider visits. The Small Ambulatory Program is to address the needs of small tribal facilities that are not competitive under the Section 301 Priority System because of their size.

URBAN INDIAN HEALTH

The Title V of the IHCIA provides specific authority focused on the provision of health services for urban Indian people with funds appropriated to IHS. IHS currently funds 34 urban Indian programs nationally and these programs provide a range of services in three broad categories: comprehensive clinical programs; limited clinical programs; and outreach and referral programs.

In addition to the 34 urban Indian health programs currently in operation, the Congress has also authorized and funded the Oklahoma City Clinic and Tulsa Clinic Demonstration Programs. Both the Oklahoma City Indian Clinic and the Tulsa Indian Clinic (now the Indian Health Care Resource Center of Tulsa) were established in the early 1970's to serve the health and social needs of the urban Indian populations of Oklahoma. With the passage of the Indian Health Care Improvement Act in September 1976, these two programs were funded by the Indian Health Service (IHS) under Title V of that law as urban programs.

In 1978, the entire State of Oklahoma was designated as a Contract Health Service Delivery Area (CHSDA) by regulation (42 CFR 36.22(a)(3)). As a statewide CHSDA Indian beneficiaries could reside anywhere in the state and maintain their eligibility for both direct services and contract health services. As a result of this change, the Oklahoma Indian population count for services was inclusive of all Indians residing in the state and counted as IHS beneficiaries in the IHS calculation for resource requirements and allocations.

The 1992 amendments to IHCIA provided for the establishment of two demonstration projects with the Tulsa and Oklahoma City clinics, "to be treated as service units in the allocation of resources and coordination of care." In establishing these demonstration projects Congress undertook a new and innovative approach to ensuring health services were accessible to all eligible populations in Oklahoma.

These demonstration projects have now established a "hybrid" system within the IHS and have a unique status. The projects are not operated strictly as an IHS facility or tribal contracted or compacted program or an urban program. Each program maintains its status under the Title V as an "urban Indian organization." Contracts are signed by the projects with the IHS, under Title V and the Buy Indian Act authority, yet the programs function like other IHS service units and report on the Resources and Patient Management System of the IHS with data utilized for inclusion in the allocation of resources. This unique status has allowed for a substantive increase in funds to the projects from the IHS based upon workload data and increases derived from substantial line-item funding increases directed by Congress in fiscal year 1994 addressing facility problems at each site. Both service population and overall utilization of services has dramatically increased since these programs became demonstration projects and as a result of the line item funds. They have been able to use the best of both urban and IHS structures to build a community controlled, high quality health system in a state designated as a contract health service delivery area.

On the other hand this hybrid system has raised a few concerns with some Oklahoma Tribes the operate their own health programs under the Indian Self Determination

and Education Assistance Act, P.L. 93–638, as amended. The issue in most basic terms is allocation of resources for tribally administered services and urban provided services for closely located beneficiary populations. In an environment of resources reduced by a growing population and greater health need, the perception of a unique or special status may cause more concern than has been observed in the past.

While the challenges for the urban Indian health programs are many, they are much the same as those faced by the Tribes and the federal operations. Our work is to assure that we all are working to fulfill our roles in the I/T/U partnership and in collaboration to raise the health status of our Indian people.

NEGOTIATED RULEMAKING; TRIBAL CONSULTATION; ADMINISTRATIVE BURDENS

While the Administration continues to have serious concerns about the proposed bills in their current forms, we are committed to working with the Committees on legislation to reauthorize this important cornerstone authority for the provision of health care to American Indians and Alaska Natives.

We are concerned that both bills would appear to broadly mandate use of negotiated rulemaking to develop all regulations to implement the IHCIA. Negotiated rulemaking is very resource-intensive for both Federal and non-Federal participants. It can be effective in appropriate circumstances, but may not be the most effective way to obtain necessary Indian provider input in the development of IHCIA rules and regulations in a given case.

Additionally, while we appreciate the value of consultation with Tribes, we have concerns about the consultation requirements. The bills would require Tribal consultation prior to the Centers for Medicare & Medicaid Services (CMS) adopting any policy or regulation, as well as require all HHS agencies to consult with urban Indian organizations prior to taking any action, or approving any action of a State, that may affect such organizations or urban Indians. Such requirements appear to be broader than the existing Tribal consultation requirement and would be very difficult to administer, given the hundreds of regulations and policies potentially covered.

We have similar concerns about the considerable indirect adverse impact of the proposed new extensive reporting requirements and other administrative burdens on IHS and CMS would divert limited resources from other activities. As IHS programs and both IHS and CMS administrative functions are funded by capped discretionary accounts, the imposition of additional administrative duties on IHS and CMS would have the practical effect of requiring cutbacks in current activities.

As we continue our thorough review of this far-reaching, complex legislation, we may have further comments on other provisions, particularly in Title IV. However, we

wish to reiterate our strong commitment to reauthorization and improvement of the Indian health care programs. We will be happy to work with the Committees, the National Tribal Steering Committee, and other representatives of the American Indian and Alaska Native communities to develop a bill fully acceptable to all stakeholders in these important programs.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act and other issues. We will be happy to answer any questions that you may have.

STATEMENT OF STEVEN B. NESMITH, ASSISTANT SECRETARY, CONGRESSIONAL AND INTERGOVERNMENTAL RELATIONS, U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

INTRODUCTION

Mr. Chairman, Mr. Vice Chairman, and Members of the Committee, thank you for inviting me to provide comments on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003.

My name is Steven B. Nesmith, and I am the Assistant Secretary for Congressional and Intergovernmental Relations. As you know, Public and Indian Housing (PIH) is responsible for the management, operation and oversight of HUD's Native American programs. These programs are available to 560 Federally-recognized and a limited number of state-recognized Indian tribes. We serve these tribes directly, or through tribally designated housing entities (TDHEs), by providing grants and loan guarantees designed to support affordable housing, community and economic development activities. Our tribal partners are diverse; they are located on Indian reservations, in Alaska Native Villages, and in other traditional Indian areas.

In addition to those duties, PIH's jurisdiction encompasses the public housing program, which aids the nation's 3,000-plus public housing agencies in providing housing and housing-related assistance to low-income families.

It is a pleasure to appear before you, and I would like to express my appreciation for your continuing efforts to improve the housing conditions of American Indian and Alaska Native peoples. Much progress is being made and tribes are taking advantage of new opportunities to improve the housing conditions of the Native American families residing on Indian reservations, on trust or restricted Indian lands, and in Alaska Native Villages. This momentum needs to be sustained as we continue to work together toward creating a better living environment throughout Indian Country.

OVERVIEW

At the outset, let me reaffirm the Department of Housing and Urban Development's support for the principle of government-to-government relations with Indian tribes.

HUD is committed to honoring this fundamental precept in our work with American Indians and Alaska Natives.

On behalf of Secretary Martinez, thank you for the opportunity to provide testimony on S. 556. The Department agrees that the Indian Health Service (IHS), a division of the Department of Health and Human Services, is vital to the well-being of individual Indian families and the Native American community as a whole. Native Americans often have no other means to receive the health care assistance and related activities provided by IHS.

HUD's Office of Native American Programs continues its ongoing dialog with IHS representatives to coordinate our activities in a manner that supports tribal sovereignty, self-determination and self-governance. The Department also participates in a federal interagency task force on infrastructure with the IHS, Environmental Protection Agency, Bureau of Indian Affairs and Department of Agriculture. It is within this perspective that the following comments are offered on the bill.

BACKGROUND ON HUD NATIVE AMERICAN PROGRAMS

In 1996, the Native American Housing Assistance and Self-Determination Act (25 U.S.C. 4101 *et seq.*) (NAHASDA) became law. NAHASDA changed the way in which housing and housing-related assistance is provided to Native American families. Prior to the Act, Indian housing authorities and Indian tribes applied for a variety of competitive, categorical grant programs, usually with differing program eligibility and reporting requirements. NAHASDA created the Indian Housing Block Grant (IHBG) Program, which is a non-competitive formula grant made to an Indian tribe or its tribally designated housing entity (TDHE).

Under the IHBG Program an Indian tribe or the TDHE submits to HUD a five-year and a one-year Indian Housing Plan (IHP). The IHP contains information about how the recipient will use its IHBG funds to engage in the six affordable housing activities authorized by NAHASDA. Once the IHP is found to be in compliance with statutory and regulatory requirements, the tribe or TDHE executes a grant agreement to receive its IHBG allocation.

The IHBG formula is based on the housing needs of each tribe and the tribe/TDHE's ongoing operation and maintenance needs for the dwelling units previously developed under the Indian Housing Program authorized by the U.S. Housing Act of 1937, as amended. The IHBG formula is calculated by dividing the total amount appropriated each fiscal year among the number of eligible grant recipients. Formula components and variables are weighted to ensure that the complexities and differences among tribes are taken into consideration. Each tribe's formula allocation reflects these factors.

The NAHASDA regulations (24 CFR 1000.306) require that the IHBG formula be reviewed by calendar year 2003 for possible modification or revision. At present, the De-

partment is engaged in negotiated rulemaking (neg-reg) with a 26-member committee comprised of a broad cross-section of tribal stakeholders. The first neg-reg session was held in April; additional monthly meetings are ongoing and scheduled through this September.

SPECIFIC COMMENTS ON S. 556

Let me turn now to our specific comments on S. 556, the Indian Health Care Improvement Act Reauthorization of 2003.

As you know, the Administration is actively reviewing S. 556 and will provide you with specific details of our analysis very shortly. The Administration has not taken a position regarding the transfer of NAHASDA funds between HUD and HHS. We do, however, have concerns about transferring NAHASDA funds between Federal agencies when NAHASDA now provides for the direct distribution of IHBG funds to tribes and their TDHE's based on a formula negotiated between tribes and the Department.

An affordable housing activity under the IHBG Program is "development," which includes infrastructure such as site improvements and the development of utilities and utilities services for housing. The provision of water and sanitation facilities is included within this category. Tribes or TDHEs may currently enter into agreements with IHS to provide these services, or they may choose another service provider. We believe this is in keeping with the policy of self-determination that is articulated in NAHASDA.

Since 1997, nearly $28 million has been transferred to IHS through TDHEs for offsite sanitation facilities. Tribes and TDHEs continue to make difficult budgetary and management decisions on how to prioritize their IHBGs, which is consistent with tribal self-determination and self-government.

Let me assure the Committee that we will work with you, our Federal partners in HHS and other Federal agencies, tribes and their TDHEs to ensure that the housing infrastructure needs in Native American communities are met in the most efficient manner possible. We are, nevertheless, concerned about any provisions that might erode the self-determination now provided for in NAHASDA.

Thank you for the opportunity to express our views on S. 556.

STATEMENT OF TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon, Mr. Chairman, Senator Inouye and members of the Committee. I am honored to testify before you today on the important issue of reauthorization of the Indian Health Care Improvement Act (IHCIA). Accompanying me today is Dr. Charles Grim, Director of the Indian Health Service (IHS). This landmark legislation forms the backbone of the system through which numerous Federal health programs serve American Indians and Alaska

Natives (AI/ANs) and encourages participation of eligible AI/ANs in these programs. Legislation pending before this Committee and over in the House has been given the highest degree of consideration by the Department. My staff has worked tirelessly to respond to this Committee's and the House Resource Committee's request for our views on H.R. 2440. I am pleased to share with you today the result of our efforts to improve services provided by the Indian Health Service, Tribes, Tribal Organizations, Alaska Native Villages and Urban Health Programs.

As Secretary of the Department of Health and Human Services (HHS), it has been my goal to improve coordination to the maximum extent possible among the operating and staff divisions at the Department and to encourage collaboration between the Department and Tribes on the many programs impacting their members. As you know, upon my arrival at HHS, I reactivated the Intradepartmental Council on Native American Affairs (ICNAA) to provide a consistent HHS policy when working with the more than 560 Federally recognized Tribes.

I am also proud of the many achievements over that past three years in the areas of access, consultation, collaboration, organization, education, sanitation facilities construction and Medicare reform. And, I have traveled widely to Indian country over the past three years and visited with Tribes from the Chippewa Indians and Oglala Sioux Tribe, to Alaska Native Villages including Point Hope and Kwethluk. I just arrived back from a visit with the Navajo Nation and will return again to Alaska later this month to meet with Native leaders in Anchorage and representatives of Southeast Alaska Rural Health Consortium in Juneau. Through my travels, I have recognized the need for improvements in facilities that provide the base from which so many health care needs are met. In this area, I would like to work closely with Congress to continue to address this need.

HHS ACCOMPLISHMENTS

The Department has improved Tribal access to HHS resources in both appropriated funding as well as to non-earmarked funds and increases in discretionary set asides. Between FY 2001 and FY 2003, HHS resources provided to Tribes or expended for the benefit of Tribes increased from $3.9 billion in 2001 to $4.4 billion in 2003. This reflects an 11% increase in access to HHS funding for Tribes during just a two-year period.

In response to Tribal leader comments at the regional Tribal consultation session, we have honored many requests including:

- Establishing a Center for Medicare and Medicaid Services (CMS)—Technical Tribal Advisory Group (TTAG), which held its first formal meeting at the Department on February 10, 2004;
- Revising the existing HHS Tribal consultation policy and involving Tribal leaders in this process;

- Helping to bridge tribal/state relations for HHS programs administered through States: HHS, the National Congress of American Indians (NCAI) and the American Public Human Services Association (APHSA) have now entered into a Federal/State/Tribal collaborative project to work together on health and human services provided to Indian Tribes and Native organizations. HHS is forming a workgroup to focus on key areas of priorities identified by Tribes (TANF, Child Welfare, Information Systems, etc.);
- Improving outcomes of Indian children and families with Diabetes by increasing education and physical activity programs; and,
- Recommending that funding be increased for the IHS Sanitation Facilities Construction (SFC): The President's FY 2005 Budget request for IHS includes an increase of $10 million for SFC.

Moreover, I am pleased that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), passed by Congress last year, included two provisions identified by Indian health programs as high priorities. First, the MMA allows Indian health programs to use Medicare's bargaining power when purchasing care from Medicare participating hospitals for their non-Medicare patients, thus stretching contract health and Urban Indian health funding further. Second, the MMA allows IHS and Tribal hospitals and clinics to bill for additional Medicare Part B services for the period 2005–2008. Finally, we are pleased that the MMA includes special provisions designed to help assure that pharmacies operated by Indian health programs, as well as other pharmacies, can participate in the temporary drug discount card and the permanent Part D drug benefit programs.

HHS VIEWS AND COMMENTS

The Department is strongly committed to the reauthorization of the IHCIA during this Congress in order to improve the health status of American Indian people and to increase the availability of health services for them. We believe that reauthorizing legislation should provide increased flexibility to enable the Department to work with Tribes to improve the quality of health care for American Indian people, to better empower the Tribes to provide quality health, to increase the availability of health care, including new approaches to delivering care, and to expand the scope of health services available to eligible American Indians and Alaska Natives.

Accordingly, I commend Congress for including in H.R. 2440 various changes that respond to concerns raised in our September 27, 2001 bill report to the Senate Committee on Indian Affairs on S. 212, a similar IHCIA reauthorization bill in the 107th Congress. Moreover, I would like to note our particular interest in, and support for, certain provisions of H.R. 2440. I an impressed with the strengthening of provisions in all program areas including:

(1) Improving recruitment and retention of qualified providers, which are the foundation upon which all services are provided by the IHS, Tribes and Tribal Organizations and Urban Health Programs (ITUs);

(2) Providing for improved health services to eligible Indians;

(3) Exempting Indians from cost sharing in the Medicaid and SCHIP programs, consistent with our current treatment of eligible Indian children under SCHIP; and,

(4) Expanding behavioral health programs to provide for much needed prevention and treatment in the areas of child sexual abuse, family violence, mental health, and other problems.

In addition, we believe that H.R. 2440, by proposing to protect eligible Indians from cost-sharing under the Medicaid and SCHIP programs, reflects the unique government-to-government relationship of the United States to Federally-recognized Indian Tribes. We would support such a proposal as consistent with current HHS policy to exempt eligible Indian children in SCHIP from premiums and cost-sharing. The proposed policy on cost-sharing would go far toward addressing the continuing under-enrollment of eligible Indian individuals and families in Medicaid.

In the area of behavioral health, H.R. 2440 provides for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but we recommend you permit the Secretary the flexibility to provide for these important programs in a manner that supports the local control and priorities of Tribes to address their specific need.

The Department does have concerns about provisions affecting the Medicare statute. Given the magnitude of the changes and new programs required by the recently enacted MMA and the challenges in implementing these changes by the statutory deadlines, we do not believe it is feasible to make additional modifications to Medicare at this time. We also have concerns about provisions impacting the Medicare trust funds, which, as you know, face significant financial challenges in the future. Finally, we have several serious concerns about the impact of H.R. 2440 on the Medicaid and SCHIP programs. Specifically, we do not believe that requiring access to unused SCHIP allotments is appropriate because it would set a precedent within SCHIP of prioritizing a population that is already eligible for services under current law, within a fixed amount of funds.

Additionally, the Department is concerned with several provisions included in the bill related to consultation requirements. H.R. 2440 proposes requirements for Federal agencies to consult with Federally-recognized Indian Tribes and Tribal organizations into statute. As exemplified by the successful outcomes of the Department's con-

sultative process with the Tribes, the Administration remains strongly committed to consultation with Tribes as provided in Presidential Executive Order 13175. Furthermore, consultation with Tribes is provided for an the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA). We, therefore, recommend striking all language regarding consultation requirements.

I reiterate our strong commitment to reauthorization and improvement of Indian health care programs, and I hope to work with this Committee and other Committees of the Congress, the National Tribal Steering Committee, and other representatives of Indian country to develop a bill that all stakeholders in these important programs can support. To this end, my staff will be communicating with your staff in the near future to share additional comments and suggestions regarding reauthorization.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee notes the following changes in existing law made by the bill, S. 556, as ordered reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

UNITED STATES CODE ANNOTATED

TITLE 25. INDIANS

CHAPTER 18—INDIAN HEALTH CARE

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

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

1611. [Congressional statement of p]*P*urpose.
1612. Health [p]*P*rofessions [r]*R*ecruitment [p]*P*rogram for Indians.
1613. Health [p]*P*rofessions [p]*P*reparatory [s]*S*cholarship [p]*P*rogram for Indians.
1613a. Indian health professions scholarships.
105. American Indians into psychology program.
106. Funding for tribes for scholarship programs.
1614. Indian health service extern programs.
1615. Continuing education allowances.
1616. Community Health Representative Program.
1616a. Indian Health Service Loan Repayment Program.
1616a–1. Scholarship and [L]*l*oan [R]*r*epayment [R]*r*ecovery [F]*f*und.
1616b. Recruitment activities.
1616c. [Tribal] *Indian* recruitment and retention program.
1616d. Advanced training and research.
1616e. *Quentin N. Burdick American Indians into* [N]*n*ursing program.
[1616e–1. Nursing school clinics.
[1616f. Tribal culture and history.]
1616g. I[NMED P]*nmed p*rogram.

1616h. Health training programs of community colleges.
[1616i. Additional incentives for health professionals.]
1616j. Retention bonus.
1616k. Nursing residency program.
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[1616m. Matching grants to tribes for scholarship programs.]
1616n. Tribal health program administration.
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124. Treatment of scholarships for certain purposes.
125. National Health Service Corps.
126. Substance abuse counselor educational curricula demonstration programs.
[1616*o*. University of South Dakota pilot program.]
1616p. Authorization of appropriations.

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1621c. Diabetes prevention, treatment, and control.
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[1621d. Hospice care feasibility study.
[1621e. Reimbursement from certain third parties of costs of health services.
[1621f. Crediting of reimbursements.]
1621g. Health services research.
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[1621h. Mental health prevention and treatment services.
[1621i. Managed care feasibility study.
[1621j. California contract health services demonstration program.
[1621k. Coverage of screening mammography.]
1621*l*. Patient travel costs.
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1621n. Comprehensive [school] health education programs.
1621*o*. Indian [y]*Y*outh [grant] [p]*P*rogram.
[1621p. American Indians Into Psychology Program.]
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213. Authority for provision of other services.
214. Indian women's health care.
215. Environmental and nuclear health hazards.
216. Arizona as a contract health service delivery area.
216A. North Dakota as a contract health service delivery area.
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220. Programs operated by Indian Tribes and Tribal Organizations.
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222. Notification of provision of emergency contract health services.
223. Prompt action on payment of claims.
[1621r. Contract health services payment study.
[1621s. Prompt action on payment of claims.
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1621u. Liability for payment.
[1621v. Office of Indian Women's Health Care.]
1621w. Authorization of appropriations.
[1621x. Limitation on use of funds.
[1622. Transferred.]

[SUBCHAPTER] *TITLE* III—[HEALTH] FACILITIES

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1636. [Grant program] *Funding* for the construction, expansion, and modernization of small ambulatory care facilities.
1637. Indian [h]*H*ealth [c]*C*are [d]*D*elivery [d]*D*emonstration [p]*P*roject.
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310. Tribal leasing.
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313. Maintenance and improvement of health care facilities.
314. Tribal management of federally owned quarters.
[1638a. Authorization of appropriations.]
1638b. Applicability of Buy American requirement.
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GENERAL PROVISIONS

§ 1601. [Congressional f]*F*indings

[The] Congress finds the following:

[(a)] *(1) Federal delivery of* health services *and funding of Indian 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 *Indians, as reflected in the Constitution, treaties, Federal statutes and the course of dealings of the United States with Indian Tribes and the United States'* [and] resulting *government-to-government relationship with Indian Tribes and trust* responsibilit[y]*ies and obligations* to[, the American] Indians [people].

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

(3) 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, Indian Tribes have secured a de facto contract which entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States.

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

[(b)] *(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 that is no less than *that of the general population* and to [encourage] *provide for* the maximum participation of Indian[s] *Tribes, Tribal Organizations, and Urban Indian Organizations* in the planning, *delivery* and management of those *health* services.

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

[(d)] *(7)* Despite such services, the unmet health needs of [the American] Indians [people are] *remain alarmingly* severe and the health status of [the] Indians is far below *the health status* [that] of the general population of the United States.

(8) The disparity to be addressed is formidable. For example, Indians suffer a death rate for diabetes mellitus that is 318 percent higher than the all races rate for the United States, a pneumonia and influenza death rate 52 percent greater, a tuberculosis death rate that is 650 percent greater, and a death rate from alcoholism that is 670 percent higher than that of the all races United States rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(D) Perinatal mortality, 2 percent.

[(E) Major congenital malformations, 4 percent.

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

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

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

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

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

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

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

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

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

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

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

[(D) Measles, 0.

[(E) Rubella, 0.

[(F) Congenital Rubella Syndrome, 0.

[(G) Mumps, 500.

[(H) Pertussis, 1,000.

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

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

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

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

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

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

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

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

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

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

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

[(61) Increase to at least 70 percent the proportion of individuals who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their

age and gender as recommended by the United States Preventive Services Task Force.

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

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

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

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

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

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

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

§1603. Definitions

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

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

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

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

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

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

(6) The term 'community college' means—

(A) a tribal college or university, or

(B) a junior or community college.

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

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

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

(A) controlling—

(i) development of diabetes;

(ii) high blood pressure;

(iii) infectious agents;

(iv) injuries;

(v) occupational hazards and disabilities;

(vi) sexually transmittable diseases; and

(vii) toxic agents; and

(B) providing—

(i) fluoridation of water; and

(ii) immunizations.

(10) The term 'fund' or 'funding' means the transfer of moneys from the Department to any eligible entity or individual under this Act by any legal means, including Funding Agreements, contracts, grants, memoranda of understanding, contracts pursuant to section 23 of the Act of April 20, 1908 (25 U.S.C. 47; commonly known as the 'Buy Indian Act'), or otherwise. Any program administered as a grant program one day before the date of enactment may continue to be administered as a grant program. This definition does not otherwise modify grant programs, except that upon request of the Indian Tribes or Tribal Organizations, discretionary grants and all categories of awarded nonrecurring funding shall be included in the Funding Agreement. Discretionary grant funds shall be governed by all the particular terms and conditions attached to such funds, unless waived by the Secretary. All particular terms and conditions attached to the discretionary grant funds must be shown in the Funding Agreement. The use of such grant funds shall be governed by the terms and conditions set forth in the Funding Agreement and not the substantive provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(11) The term 'Funding Agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, services, functions, and activities to Indian Tribes and Tribal Organizations from the Secretary under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(12) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, advanced practice nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic

medicine, environmental health and engineering, allied health professions, and any other health profession.

(13) The term 'health promotion' means—

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

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

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

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

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

(F) promoting adequate opportunity for spiritual, religious, and Traditional Health Care Practices; and

(G) providing adequate and appropriate programs, including, but not limited to—

(i) abuse prevention (mental and physical);

(ii) community health;

(iii) community safety;

(iv) consumer health education;

(v) diet and nutrition;

(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;

(vii) environmental health;

(viii) exercise and physical fitness;

(ix) avoidance of fetal alcohol disorders;

(x) first aid and CPR education;

(xi) human growth and development;

(xii) injury prevention and personal safety;

(xiii) behavioral health;

(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;

(xv) personal health and wellness practices;

(xvi) personal capacity building;

(xvii) prenatal, pregnancy, and infant care;

(xviii) psychological well-being;

(xix) reproductive health and family planning;

(xx) safe and adequate water;

(xxi) safe housing relative to eliminating, reducing, or preventing contaminants which create unhealthy housing conditions;

(xxii) safe work environments;

(xxiii) stress control;

(xxiv) substance abuse;

(xxv) sanitary facilities;

(xxvi) sudden infant death syndrome prevention;

(xxvii) tobacco use cessation and reduction;

(xxviii) violence prevention; and

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

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

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

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

(B) any Tribal Health Program; or

(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of April 30, 1908 (25 U.S.C. 47), commonly known as the 'Buy Indian Act'.

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

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

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

[(a)**]** *(19) The term* **[**"**]**'Secretary**[**"**]**', unless otherwise designated, means the Secretary of Health and Human Services.

[(b)**]** *(20) The term* **[**"**]**'Service**[**"**]**' means the Indian Health Service.

[(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

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

[(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and

which includes the maximum participation of Indians in all phases of its activities.]

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

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

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

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

(25) The term 'Traditional Health Care Practices' means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony.

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

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

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

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

[(f) "] *(30) The term '*Urban Indian[”]*'* means any individual who resides in an [u]*U*rban [c]*C*enter[, as defined in subsection (g) of this section,] and who meets [one] *1* or more of the [four] *following* criteria*:* [in subsection (c)(1) though (4) of this section.]

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

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

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

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

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

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

[(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.

[(i) "Area office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

[(j) "Service unit" means—

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

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

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

[(k) "Health promotion" includes—

[(1) cessation of tobacco smoking,

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

[(3) improvement of nutrition,

[(4) improvement in physical fitness,

[(5) family planning,

[(6) control of stress, and

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

[(l) "Disease prevention" includes—

[(1) immunizations,

[(2) control of high blood pressure,

[(3) control of sexually transmittable diseases,

[(4) prevention and control of diabetes,

[(5) control of toxic agents,

[(6) occupational safety and health,

[(7) accident prevention,

[(8) fluoridation of water, and

[(9) control of infectious agents.

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

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

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

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

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

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

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

The purpose of this [subchapter] *title* is to increase, *to the maximum extent feasible*, the number of Indians entering the health professions and *providing health services, and* to assure an [adequate] *optimum* supply of health professionals to the *Indian Health Programs* [Service, Indian tribes, tribal organizations,] and [u]*U*rban Indian [o]*O*rganizations involved in the provision of health care to Indians [people].

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

(a) [GRANTS FOR EDUCATION AND TRAINING] *IN GENERAL.*—

The Secretary, acting through the Service, shall make [grants] *funds available* to public or nonprofit private health or educational entities, *Tribal Health Programs, or Urban Indian Organizations* [or Indian tribes or tribal organizations] to assist such entities in meeting the costs of—

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

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

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

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

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

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

(1) *APPLICATION.—Funds under this section shall require that* [No grant may be made under this section unless] an application [therefor] has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe *pursuant to this Act*. The Secretary shall give a preference to applications submitted by *Tribal Health Programs or Urban Indian Organizations* [Indian tribes or tribal organizations].

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

(c) DEFINITION OF INDIAN.—For purposes of this section and sections 103 and 104, the term 'Indian' shall, in addition to the meaning given that term in section 4, also mean any individual who is an Urban Indian.

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

(a) [REQUIREMENTS] *SCHOLARSHIPS AUTHORIZED.*—

The Secretary, acting through the Service, shall *provide scholarships* [make scholarship grants] to Indians who—

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

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

(b) PURPOSES.—[AND DURATION OF GRANTS; PREPROFESSIONAL AND PREGRADUATE EDUCATION]

Scholarship*s provided* [grants made] pursuant to this section shall be for the following purposes:

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

(2) Pregraduate education of any *recipient* [grantee] leading to a baccalaureate degree in an approved course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years [(or the part-time equivalent thereof, as determined by the Secretary)]. *An extension of up to 2 years (or the part-time equivalent thereof, as determined by the Secretary pursuant to regulations issued pursuant to this Act) may be approved*.

(c) [COVERED EXPENSES] *OTHER CONDITIONS.*—

Scholarships [grants made] under this section—

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

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

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

[(d) BASIS FOR DENIAL OF ASSISTANCE

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

[(e) ELIGIBILITY FOR ASSISTANCE UNDER OTHER FEDERAL PROGRAMS

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

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

(a) *IN* GENERAL.—[AUTHORITY]

(1) AUTHORITY.—[In order to provide health professionals to Indians, Indian tribes, tribal organizations, and urban Indian organizations, t]*T*he Secretary, acting through the Service [and in accordance with this section], shall make scholarships [grants] to Indians who are enrolled full or part time in [appropriately] accredited schools [and] pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section *338A of the Public Health Services Act (42 U.S.C. 254l)* [of Title 42], except as provided in subsection (b) of this section.

(2) ALLOCATION BY FORMULA.—Except as provided in paragraph (3), the funding authorized by this section shall be allocated by Service Area by a formula developed in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. Such formula shall consider the human resource development needs in each Service Area.

(3) CONTINUITY OF PRIOR SCHOLARSHIPS.—Paragraph (2) shall not apply with respect to individual recipients of scholarships provided under this section (as in effect 1 day prior to the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004) until such time as the individual completes the course of study that is supported through such scholarship.

(4) CERTAIN DELEGATION NOT ALLOWED.—The administration of this section shall be a responsibility of the Assistant Secretary and shall not be delegated in a Funding Agreement.

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

[(1) The Secretary, acting through the Service, shall determine who shall receive scholarships under subsection (a) of this section and shall determine the distribution of such schol-

arships among such health professions on the basis of the relative needs of Indians for additional service in such health professions.

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

(1)[(3)(A)] *OBLIGATION MET.*—The [A]*a*ctive duty service obligation under a written contract with the Secretary under section *338A of the Public Health Service Act (42 U.S.C.* 254l) [of Title 42] that an [individual] *Indian* has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice *on an equivalent year-for-year obligation*, by service *in one or more of the following*:[—]

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

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

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

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

(2)[(B)] *OBLIGATION DEFERRED.*—At the request of any individual who has entered into a contract referred to in *paragraph (1)* [subparagraph (A)] and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

(A)[(i)] No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service [that is required] under this *sub*section.

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

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

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

specified *under* [in] that *paragraph* [subparagraph] that—

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

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

(3)[(D)] *PRIORITY WHEN MAKING ASSIGNMENTS.*—Subject to *paragraph (2)* [subparagraph (C)], the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in *paragraph (1)* [subparagraph (A)], shall give priority to assigning individuals to service in those programs specified in *paragraph (1)* [subparagraph (A)] that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

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

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

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

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

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

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

(d) BREACH OF CONTRACT.—

(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004 if that individual—

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

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

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

(C)[(iii)] voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training[,]*;* or

(D)[(iv)] fails to accept payment, or instructs the educational institution in which he *or she* is enrolled not to ac-

cept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract[, shall be liable to the United States for the amount which has been paid to him, on his behalf, under the contract].

(2)[(B)] *OTHER BREACHES.*—If for any reason not specified in *paragraph (1)* [subparagraph (A)] an individual breaches *a* [his] written contract by failing either to begin such individual's service obligation *required* under *such contract* [this section] or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (*l*) of section *110* [1616a of this title] in the manner provided for in such subsection.

(3)[(C)] *CANCELLATION UPON DEATH OF RECIPIENT.*—Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(4)[(D)] *WAIVERS AND SUSPENSIONS.*—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 Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations*, determines that—

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

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

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

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

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

[(c) PLACEMENT OFFICE

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

§ 105. American Indians into Psychology Program

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall provide funding grants to at least 3 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

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

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

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

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

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

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

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

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

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

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

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

(1) in an Indian Health Program;

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

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

§ 106. Funding for Tribes for Scholarship Programs

(a) IN GENERAL.—

(1) FUNDING AUTHORIZED.—The Secretary, acting through the Service, shall make funds available to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(2) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 104.

(3) APPLICATION.—An application for funds under paragraph (1) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(b) REQUIREMENTS.—

(1) IN GENERAL.—A Tribal Health Program receiving funds under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

(2) COSTS.—With respect to costs of providing any scholarship pursuant to subsection (a)—

(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

(B) 20 percent of such costs may be paid from any other source of funds.

(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions contemplated by this Act.

(d) CONTRACT.—In providing scholarships under subsection (b), the Secretary and the Tribal Health Program shall enter into a written contract with each recipient of such scholarship. Such contract shall—

(1) obligate such recipient to provide service in an Indian Health Program or Urban Indian Organization, in the same Service Area where the Tribal Health Program providing the scholarship is located, for—

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

(B) such greater period of time as the recipient and the Tribal Health Program may agree;

(2) provide that the amount of the scholarship—

(A) may only be expended for—

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

(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), 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 for which the scholarship is

provided, the total amount required for the year for the purposes authorized in this clause; and

(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

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

(4) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

(e) BREACH OF CONTRACT.—

(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

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

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

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

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

(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

(3) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who receives an Indian Health Scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(4) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Tribal Health Programs involved or on the basis of information collected through such other means as the Secretary deems appropriate.

(f) RELATION TO SOCIAL SECURITY ACT.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

(1) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care

or on the basis that payment for such care will be made pursuant to a program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX or title XXI of such Act; and

(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX, or the State child health plan under title XXI, of such Act to provide service to individuals entitled to medical assistance or child health assistance, respectively, under the plan.

(g) CONTINUANCE OF FUNDING.—The Secretary shall make payments under this section to a Tribal Health Program for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Tribal Health Program has not complied with the requirements of this section.

§ 1614. Indian *H*[h]ealth *S*[s]ervice *E*[e]xtern *P*[p]rograms

(a) EMPLOYMENT *PREFERENCE*.—[of scholarship grantees during nonacademic periods] *Any individual who receives a scholarship pursuant to section 104 or 106 shall be given preference for employment in the Service, or may be employed by a Tribal Health Program or an Urban Indian Organization, or other agencies of the Department as available, during any nonacademic period of the year.*

(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—

[Any individual who receives a scholarship grant pursuant to section 1613a of this title shall be entitled to employment in the Service during any nonacademic period of the year.] Periods of employment pursuant to this subsection shall not be counted in determining [the] fulfillment of the service obligation incurred as a condition of the scholarship [grant].

(c) TIMING; LENGTH OF EMPLOYMENT.—

[(b) EMPLOYMENT OF MEDICAL AND OTHER STUDENTS DURING NONACADEMIC PERIODS]

Any individual enrolled in a *program, including a high school program, authorized under section 102(a)* [course of study in the health professions] may be employed by the Service *or by a Tribal Health Program or an Urban Indian Organization* during any nonacademic period of the year. Any such employment shall not exceed *120* [one hundred and twenty] days during any calendar year.

(d) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.—

[(c) EMPLOYMENT WITHOUT REGARD TO COMPETITIVE PERSONNEL SYSTEM OR AGENCY PERSONNEL LIMITATION; COMPENSATION]

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

§ 1615. Continuing *E*[e]ducation *A*[a]llowances

[(a) DISCRETIONARY AUTHORITY; SCOPE OF ACTIVITIES]

In order to encourage *health professionals, including community health representatives and emergency medical technicians*, [physicians, dentists, nurses, and other health professionals] to join or continue in *an Indian Health Program or an Urban Indian Organization* [the Service] and to provide their services in the rural and remote areas where a significant portion of [the] Indian*s* [people] reside[s], the Secretary, acting through the Service, may provide allowances to health professionals employed in *an Indian Health Program or an Urban Indian Organization* [the Service] to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

[(b) LIMITATION

[Of amounts appropriated under the authority of this subchapter for each fiscal year to be used to carry out this section, not more than $1,000,000 may be used to establish postdoctoral training programs for health professionals.]

§ 1616. Community Health Representative Program

(a) *IN GENERAL.*—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (*commonly* [, popularly] known as the Snyder Act), the Secretary, *acting through the Service,* shall maintain a Community Health Representative Program under which *Indian Health Programs* [the Service]—

(1) provide[s] for the training of Indians as *community health representatives;* [health paraprofessionals,] and

(2) use[s] such *community health representatives* [paraprofessionals] in the provision of health care, health promotion, and disease prevention services to Indian communities.

(b) *DUTIES.*—The [SECRETARY, ACTING THROUGH THE] COMMUNITY HEALTH REPRESENTATIVE PROGRAM OF THE SERVICE, SHALL—

(1) provide a high standard of training for [paraprofessionals to C]*c*ommunity [H]*h*ealth [R]*r*epresentatives to ensure that the [C]*c*ommunity [H]*h*ealth [R]*r*epresentatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by [such] *the* Program[,]*;*

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

(A) combines education in the theory of health care with supervised practical experience in the provision of health care[,]*;* and

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

(3) maintain a system which identifies the needs of [C]*c*ommunity [H]*h*ealth [R]*r*epresentatives for continuing education in health care, health promotion, and disease prevention, and *develop* [maintain] programs that meet the needs for [such] continuing education[,]*;*

(4) maintain a system that provides close supervision of Community Health Representatives[,]*;*

(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated[,]*;* and

(6) promote [t]*T*raditional [h]*H*ealth [c]*C*are [p]*P*ractices of the Indian [t]*T*ribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

§ 1616a. Indian Health Service Loan Repayment Program

(a) ESTABLISHMENT

[(1)] The Secretary, acting through the Service, shall establish *and administer* a program to be known as the [Indian Health] Service Loan Repayment Program (hereinafter referred to as the "Loan Repayment Program") in order to *ensure* [assure] an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations.*

[(2) For the purposes of this section—

[(A) the term "Indian health program" means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

[(i) directly by the Service;

[(ii) by any Indian tribe or tribal or Indian organization pursuant to a contract under—

[(I) the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.], or

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

[(iii) by an urban Indian organization pursuant to subchapter IV of this chapter; and

[(B) the term "State" has the same meaning given such term in section 254d(i)(4) of Title 42.]

(b) *ELIGIBLE INDIVIDUALS*.—[ELIGIBILITY]

To be eligible to participate in the Loan Repayment Program, an individual must—

(1)(A) be enrolled—

(i) in a course of study or program in an accredited institution[,] (as determined by the Secretary *under section 338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(c)(i)))*[, within any State] and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

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

(B) have—

(i) a degree in a health profession; and

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

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

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

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

(D) be employed in an Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* without a service obligation; and

(3) submit to the Secretary an application for a contract described in subsection *(e)* [(f) of this section].

(c) APPLICATION [AND CONTRACT FORMS].—

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

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

(3) *TIMELY AVAILABILITY OF FORMS*.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

(d) *PRIORITIES*.—[VACANCIES; PRIORITY]

(1) *LIST*.—Consistent with *subsection (k)* [paragraph (3)], the Secretary[, acting through the Service and in accordance with subsection (k), of this section,] shall annually—

(A) identify the positions in each Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* for which there is a need or a vacancy[,]*;* and

(B) rank those positions in order of priority.

(2) *APPROVALS.—Notwithstanding* [Consistent with] the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall—

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

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

(i) individuals recruited through the efforts of *an* Indian *Health Program or Urban Indian Organization; and* [tribes or tribal or Indian organizations.]

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

[(3)(A) Subject to subparagraph (B), of the total amounts appropriated for each of the fiscal years 1993, 1994, and 1995 for loan repayment contracts under this section, the Secretary shall provide that—

[(i) not less than 25 percent be provided to applicants who are nurses, nurse practitioners, or nurse midwives; and

[(ii) not less than 10 percent be provided to applicants who are mental health professionals (other than applicants described in clause (i)).

[(B) The requirements specified in clause (i) or clause (ii) of subparagraph (A) shall not apply if the Secretary does not receive the number of applications from the individuals described in clause (i) or clause (ii), respectively, necessary to meet such requirements.]

(e) *RECIPIENT CONTRACTS.*—[APPROVAL]

(1) *CONTRACT REQUIRED.*—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in *paragraph (2)* [subsection (f) of this section].

(2) *CONTENTS OF CONTRACT.*—[The Secretary shall provide written notice to an individual promptly on—

[(A) the Secretary's approving, under paragraph (1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

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

[(f) CONTRACT TERMS]

The written contract referred to in this section between the Secretary and an individual shall contain—

(A)[(1)] an agreement under which—

(i)[(A)] subject to subparagraph *(C)*[(3)], the Secretary agrees—

(I)[(i)] to pay loans on behalf of the individual in accordance with the provisions of this section[,]*;* and

(II)[(ii)] to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a *Tribal Health Program or Urban Indian Organization* [tribe or Indian organization] as provided in *clause (ii)(III)*; [subparagraph (B)(iii),] and

(ii)[(B)] subject to *sub*paragraph *(C)*[(3)], the individual agrees—

(I)[(i)] to accept loan payments on behalf of the individual;

(II)[(ii)] in the case of an individual described in subsection (b)(1)—

(aa)[(I)] to maintain enrollment in a course of study or training described in subsection (b)(1)(A) [of this section] until the individual

completes the course of study or training[,]*;* and

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

(III)[(iii)] to serve for a time period (hereinafter in this section referred to as the ["]'period of obligated service'["]) equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* to which the individual may be assigned by the Secretary;

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

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

(D)[(4)] a statement of the damages to which the United States is entitled under subsection *(1)* [of this section] for the individual's breach of the contract; and

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

(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—

(1) the Secretary's approving, under subsection (e)(1), of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

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

(g) *PAYMENTS*.—[LOAN REPAYMENT PURPOSES; MAXIMUM AMOUNT; TAX LIABILITY REIMBURSEMENT; SCHEDULE OF PAYMENTS]

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

(A) tuition expenses;

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

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

(2)[(A)] *AMOUNT*.—For each year of obligated service that an individual contracts to serve under subsection *(e)*,[(f) of this section] the Secretary may pay up to $35,000 [(]or an amount equal to the amount specified in section *338B(g)(2)(A) of the Public Health Service Act, whichever is more,* [254*l*–1(g)(2)(A) of Title 42)] on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

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

(B)[(ii)] provides an incentive to serve in Indian [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations* with the greatest shortages of health professionals; and

(C)[(iii)] provides an incentive with respect to the health professional involved remaining in an Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

(3)[(B)] *TIMING*.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

(4)[(3)] For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary—

(A) in addition to such payments, may make payments to the individual in an amount not less than 20 percent and not more than 39 percent of the total amount of loan repayments made for the taxable year involved; and

(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

(5)[(4)] *PAYMENT SCHEDULE*.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

(h) *EMPLOYMENT CEILING*.—[EFFECT ON EMPLOYMENT CEILING OF DEPARTMENT OF HEALTH AND HUMAN SERVICES]

Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section[, while undergoing academic training,] shall not be counted against any employment ceiling affecting the Department [of Health and Human Services] *while those individuals are undergoing academic training.*

(i) *RECRUITMENT*.—[RECRUITING PROGRAMS]

The Secretary shall conduct recruiting programs for the Loan Repayment Program and other [health professional programs of the]

Service *manpower programs* at educational institutions training health professionals or specialists identified in subsection (a) [of this section].

(j) *APPLICABILITY OF LAW*.—[PROHIBITION OF ASSIGNMENT TO OTHER GOVERNMENT DEPARTMENTS]

Section *214 of the Public Health Service Act (42 U.S.C. 215)* [215 of Title 42] shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

(k) *ASSIGNMENT OF INDIVIDUALS*.—[STAFF NEEDS OF HEALTH PROGRAMS ADMINISTERED BY INDIAN TRIBES]

The Secretary, in assigning individuals to serve in Indian [h]*H*ealth [p]*P*rograms *or Urban Indian Organizations* pursuant to contracts entered into under this section, shall—

(1) ensure that the staffing needs of *Tribal* [Indian h]*H*ealth [p]*P*rograms *and Urban Indian Organizations* [administered by an Indian tribe or tribal or health organization] receive consideration on an equal basis with programs that are administered directly by the Service; and

(2) give priority to assigning individuals to Indian [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations* that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

(*l*) *BREACH OF CONTRACT*.—[VOLUNTARY TERMINATION OF STUDY OR DISMISSAL FROM EDUCATIONAL INSTITUTION; COLLECTION OF DAMAGES]

(1) *SPECIFIC BREACHES*.—An individual who has entered into a written contract with the Secretary under this section and *has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract if that individual* [who]—

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

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

(ii) voluntarily terminates such enrollment; or

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

(B) is enrolled in a graduate training program[,] *and* fails to complete such training program[, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii) of this section,].

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

(2) *OTHER BREACHES; FORMULA FOR AMOUNT OWED*.—If, for any reason not specified in paragraph (1), an individual breaches his *or her* written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection *(e)(2)* [(f) of this

section**]**, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: A=3Z(t – s/t) in which—

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

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

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

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

(3) DEDUCTIONS IN MEDICARE PAYMENTS.—Amounts not paid within such period shall be subject to collection through deductions in **[**M**]***m*edicare payments pursuant to section *1892 of the Social Security Act* **[**1395ccc of Title 42**]**.

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

(5) RECOVERY OF DELINQUENCY.—

*(A)***[**(B)**]** *IN GENERAL.*—If damages described in *paragraph (4)* **[**subparagraph (A)**]** are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

(i) *use* **[**utilize**]** collection agencies contracted with by the Administrator of **[**the**]** General Services **[**Administration**]**; or

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

*(B)***[**(C)**]** *REPORT.*—Each contract for recovering damages pursuant to this subsection shall provide that the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of **[**T**]***title* 31, *United States Code*, shall apply to any such contract to the extent not inconsistent with this subsection.

(m) *WAIVER OR SUSPENSION OF OBLIGATION.*—**[**CANCELLATION OR WAIVER OF OBLIGATIONS; BANKRUPTCY DISCHARGE**]**

[(1) Any obligation of an individual under the Loan Repayment program for service or payment of damages shall be canceled upon the death of the individual.**]**

(1) **[**(2)**]** *IN GENERAL.*—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual

and if enforcement of such obligation with respect to any individual would be unconscionable.

(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

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

(4) *BANKRUPTCY*.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under [T]*t*itle 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

(n) [ANNUAL R]*R*EPORT.—

The Secretary shall submit to the President, for inclusion in each report required to be submitted to [the] Congress under section *801* [1671 of this title], a report concerning the previous fiscal year which sets forth *by Service Area the following:*[—]

(1) *A list of* the health professional positions maintained by *Indian Health Programs and Urban Indian Organizations* [the Service or by tribal or Indian organizations] for which recruitment or retention is difficult[;].

(2) [t]*T*he number of Loan Repayment Program applications filed with respect to each type of health profession[;].

(3) [t]*T*he number of contracts described in subsection *(e)* [(f) of this section] that are entered into with respect to each health profession[;].

(4) [t]*T*he amount of loan payments made under this section, in total and by health profession[;].

(5) [t]*T*he number of scholarships [grants] that are provided under sections *104 and 106* [1613a of this title] with respect to each health profession[;].

(6) [t]*T*he amount of scholarships [grants] provided under section *104 and 106* [1613a of this title], in total and by health profession[;].

(7) [t]*T*he number of providers of health care that will be needed by Indian [h]*H*ealth [p]*P*rograms *and Urban Indian Organizations*, by location and profession, during the *3* [three] fiscal years beginning after the date the report is filed[; and].

(8) [t]*T*he measures the Secretary plans to take to fill the health professional positions maintained by *Indian Health Programs or Urban Indian Organizations* [the Service or by tribes or tribal or Indian organizations] for which recruitment or retention is difficult.

§ 1616a–1. Scholarship and Loan Repayment Recovery Fund

(a) ESTABLISHMENT

There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereinafter in this section referred to as the *'LRRF'* ["Fund"]). The *LRRF* [Fund] shall consist of such amounts

as may be *collected from individuals* [appropriated to the Fund] under section *104(d), section 106(e), and section 110(l) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF* [subsection (b) of this section]. *All* [A]*a*mounts *collected*, appropriated, *or earned relative to the LRRF* [for the Fund] shall remain available until expended.

[(b) AUTHORIZATION OF APPROPRIATIONS

[For each fiscal year, there is authorized to be appropriated to the Fund an amount equal to the sum of—

[(1) the amount collected during the preceding fiscal year by the Federal Government pursuant to—

[(A) the liability of individuals under subparagraph (A) or (B) of section 1613a(b)(5) of this title for the breach of contracts entered into under section 1613a of this title; and

[(B) the liability of individuals under section 1616a(*l*) of this title for the breach of contracts entered into under section 1616a of this title; and

[(2) the aggregate amount of interest accruing during the preceding fiscal year on obligations held in the Fund pursuant to subsection (d) of this section and the amount of proceeds from the sale or redemption of such obligations during such fiscal year.]

(b) [(c)] USE OF FUNDS

(1) *BY SECRETARY.*—Amounts in the *LRRF* [Fund and available pursuant to appropriation Acts] may be expended by the Secretary, acting through the Service, to make payments to an Indian *Health Program*—[tribe or tribal organization administering a health care program pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]—]

(A) to which a scholarship recipient under section *104 and 106* [1613a of this title] or a loan repayment program participant under section *110* [1616a of this title] has been assigned to meet the obligated service requirements pursuant to *such* sections; and

(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section *104, 106, or 110*. [1613a of this title or section 1616a of this title.]

(2) *BY TRIBAL HEALTH PROGRAMS.—A Tribal Health Program,* [An Indian tribe or tribal organization] receiving payments pursuant to paragraph (1) may expend the payments to *provide scholarships or* recruit and employ, directly or by contract, health professionals to provide health care services.

(c) [(d)] INVESTMENT OF [EXCESS F]*F*UNDS.—

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

(d) SALE OF OBLIGATIONS.—[(2)] Any obligation acquired by the *LRRF* [Fund] may be sold by the Secretary of the Treasury at the market price.

§ 1616b. Recruitment *A*[a]ctivities

(a) *REIMBURSEMENT FOR TRAVEL.*—The Secretary, *acting through the Service,* may reimburse health professionals seeking positions *with Indian Health Programs or Urban Indian Organizations* [in the Service], including *unpaid student volunteers and* individuals considering entering into a contract under section *110* [1616a of this title], and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

(b) *RECRUITMENT PERSONNEL.*—The Secretary, acting through the Service, shall assign one individual in each [a]*A*rea [o]*O*ffice to be responsible on a full-time basis for recruitment activities.

§ 1616c. *Indian* [Tribal r]*R*ecruitment and *R*[r]etention *P*[p]rogram

(a) *IN GENERAL.*—[PROJECTS FUNDED ON COMPETITIVE BASIS]

The Secretary, acting through the Service, shall fund *innovative demonstration projects for a period not to exceed 3 years to enable Tribal Health Programs and Urban Indian Organizations to recruit, place, and retain health professionals to meet their staffing needs.* [, on a competitive basis, projects to enable Indian tribes and tribal and Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 1616a(a)(2) of this title).]

(b) *ELIGIBLE ENTITIES; APPLICATION.*—[ELIGIBILITY]

[(1)] Any *Tribal Health Program or Urban Indian Organization* [Indian tribe or tribal or Indian organization] may submit an application for funding of a project pursuant to this section.

[(2) Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be given an equal opportunity with programs that are administered directly by the Service to compete for, and receive, grants under subsection (a) of this section for such projects.]

§ 1616d. Advanced *T*[t]raining and *R*[r]esearch

(a) *DEMONSTRATION* [ESTABLISHMENT OF P]*PROGRAM*

The Secretary, acting through the Service, shall establish a *demonstration project* [program] to enable health professionals *who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time* to pursue advanced training or research in areas of study for which the Secretary determines a need exists. [In selecting participants for a program established under this subsection, the Secretary, acting through the Service, shall give priority to applicants who are employed by the Indian Health Service, Indian tribes, tribal organization, and urban Indian organizations, at the time of the submission of the applications.]

(b) *SERVICE OBLIGATION.*—[OBLIGATED SERVICE]

An individual who participates in a program under subsection (a) [of this section], where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian [h]*H*ealth [p]*P*rogram *or Urban Indian Organization* [(as defined in section 1616a(a)(2) of this title)] for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after *the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004,* [October 29, 1992,] the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (*l*) of section *110* [1616a of this title] in the manner provided for in such subsection.

(c) *EQUAL OPPORTUNITY FOR PARTICIPATION*.—[ELIGIBILITY]

Health professionals from *Tribal Health Programs and Urban Indian Organizations* [Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]] shall be given an equal opportunity to participate in the program under subsection (a) [of this section].

[§ 1616e. Nursing program

[(a) GRANTS

[The Secretary, acting through the Service, shall provide grants to—

[(1) public or private schools of nursing,

[(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 2397h(2) of Title 20), and

[(3) nurse midwife programs, and nurse practitioner programs, that are provided by any public or private institution,

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

[(b) PURPOSES

[Grants provided under subsection (a) of this section may be used to—

[(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or nurse practitioners,

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

[(3) provide a program that encourages nurses, nurse midwives, and nurse practitioners to provide, or continue to provide, health care services to Indians,

[(4) provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and nurse practitioners, or

[(5) provide any program that is designed to achieve the purpose described in subsection (a) of this section.

[(c) APPLICATION

[Each application for a grant under subsection (a) of this section shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

[(d) PREFERENCE

[In providing grants under subsection (a) of this section, the Secretary shall extend a preference to—

[(1) programs that provide a preference to Indians,

[(2) programs that train nurse midwives or nurse practitioners,

[(3) programs that are interdisciplinary, and

[(4) programs that are conducted in cooperation with a center for gifted and talented Indian students established under section 2624(a) of this title.]

§ *115.* [(e)] Quentin N. Burdick American Indians Into Nursing Program

(a) GRANTS AUTHORIZED.—For the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians, the Secretary, acting through the Service, shall provide grants to the following:

(1) Public or private schools of nursing.

(2) Tribal colleges or universities.

(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for one or more of the following:

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

(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

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

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

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

(c) APPLICATIONS.—Each application for funding under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

(1) Programs that provide a preference to Indians.

(2) Programs that train nurse midwives or advanced practice nurses.

(3) Programs that are interdisciplinary.

(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

(e) QUENTIN N. BURDICK PROGRAM GRANT.—

The Secretary shall provide one of the grants authorized under subsection (a) [of this section] to establish and maintain a program at the University of North Dakota to be known as the ["] 'Quentin N. Burdick American Indians Into Nursing Program' ["]. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section *117(b)* [1616g(b) of this title] and the Quentin N. Burdick American Indians Into Psychology Program established under section *105(b)* [1621p(b) of this title].

(f) *ACTIVE DUTY* SERVICE *O*[O]BLIGATION.—

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

(1) [(A)] in the [Indian Health] Service;

(2) [(B)] in a program of an *Indian Tribe or Tribal Organization* conducted under the *Indian Self-Determination and Education Assistance Act (including programs under agreements with the Bureau of Indian Affairs)* [a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]];

(3)[(C)] in a program assisted under *title V* [subchapter IV] of this Act [chapter]; or

(4) [(D)]1 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.

[(g) AUTHORIZATION OF APPROPRIATIONS

[Beginning with fiscal year 1993, of the amounts appropriated under the authority of this subchapter for each fiscal year to be used to carry out this section, not less than $1,000,000 shall be used to provide grants under subsection (a) of this section for the training of nurse midwives, nurse anesthetists, and nurse practitioners.

[§ 1616e–1. Nursing school clinics

[(a) GRANTS

[In addition to the authority of the Secretary under section 1616e(a)(1) of this title, the Secretary, acting through the Service, is authorized to provide grants to public or private schools of nursing for the purpose of establishing, developing, operating, and administering clinics to address the health care needs of Indians, and to provide primary health care services to Indians who reside on or within 50 miles of Indian country, as defined in section 1151 of Title 18.

[(b) PURPOSES

[Grants provided under subsection (a) of this section may be used to—

[(1) establish clinics, to be run and staffed by the faculty and students of a grantee school, to provide primary care services in areas in or within 50 miles of Indian country (as defined in section 1151 of Title 18);]

[(2) provide clinical training, program development, faculty enhancement, and student scholarships in a manner that would benefit such clinics; and

[(3) carry out any other activities determined appropriate by the Secretary.

[(c) AMOUNT AND CONDITIONS

[The Secretary may award grants under this section in such amounts and subject to such conditions as the Secretary deems appropriate.

[(d) DESIGN

[The clinics established under this section shall be designed to provide nursing students with a structured clinical experience that is similar in nature to that provided by residency training programs for physicians.

[(e) REGULATIONS

[The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

[(f) AUTHORIZATION TO USE AMOUNTS

[Out of amounts appropriated to carry out this subchapter for each of the fiscal years 1993 through 2000 not more than $5,000,000 may be used to carry out this section.]

§ 1616f. Tribal *Cultural Orientation.* [culture and history]

(a) *CULTURAL EDUCATION OF EMPLOYEES.*—[PROGRAM ESTABLISHED]

The Secretary, acting through the Service, shall *require that* [establish a program under which] appropriate employees of the Service who serve [particular] Indian [t]*T*ribes *in each Service Area* [shall] receive educational instruction in the history and culture of such *Indian T*[t]ribes and *their relationship to* [in the history of] the Service.

(b) *PROGRAM.*—[TRIBALLY-CONTROLLED COMMUNITY COLLEGES] *In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—*

[To the extent feasible, the program established under subsection (a) of this section shall—]

(1) *be developed in consultation with the affected Indian Tribes, Tribal Organizations, and Urban Indian Organizations;* [be carried out through tribally-controlled community colleges (within the meaning of section 1801(4) of this title) and tribally controlled postsecondary vocational institutions (as defined in section 2397h(2) of Title 20),]

(2) *be carried out through tribal colleges or universities;* [be developed in consultation with the affected tribal government, and]

(3) include instruction in *American Indian* [Native American] studies*; and*[.]

(4) describe the use and place of Traditional Health Care Practices of the Indian Tribes in the Service Area.

§ 1616g. INMED Program

(a) GRANTS *AUTHORIZED.*—

The Secretary, *acting through the Service,* is authorized to provide grants to [at least 3] colleges and universities for the purpose of maintaining and expanding the *Indian* [Native American] health careers recruitment program known as the ["] 'Indians into Medicine Program'["] (hereinafter in this section referred to as ["] 'INMED'["]) as a means of encouraging Indians to enter the health professions.

(b) *QUENTIN N. BURDICK GRANT.*—[UNIVERSITY OF NORTH DAKOTA]

The Secretary shall provide one of the grants authorized under subsection (a) [of this section] to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Programs', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section *105(b)* [1621p(b) of this title] and the Quentin N. Burdick American Indians Into Nursing Program established under section *115* [1616e of this title].

(c) REGULATIONS.—[; CONTENTS OF RECRUITMENT PROGRAM]

[(1)] The Secretary, *pursuant to this Act,* shall develop regulations *to govern* [for the competitive awarding of the] grants *pursuant to* [provided under] this section.

(*d*) *REQUIREMENTS.*—[(2)] Applicants for grants provided under this section shall agree to provide a program which—

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

(2)[(B)] incorporates a program advisory board comprised of representatives from the *Indian* tribes and *Indian* communities which will be served by the program[,]*;*

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

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

(5)[(E)] to the maximum extent feasible, employs qualified Indians in the program.

[(d) REPORT TO CONGRESS

[By no later than the date that is 3 years after November 23, 1988, the Secretary shall submit a report to the Congress on the program established under this section including recommendations for expansion or changes to the program.]

§ 1616h. Health [t]*T*raining [p]*P*rograms of [c]*C*ommunity [c]*C*olleges

(a) GRANTS *TO ESTABLISH PROGRAMS.*—

(1) *IN GENERAL.*—The Secretary, acting through the Service, shall award grants to *accredited and accessible* community colleges for the purpose of assisting *such* [the] community col-

leges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on *or near a* [an Indian] reservation or in *an Indian Health Program* [a tribal clinic].

(2) *AMOUNT OF GRANTS.—T*[t]he amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $100,000.

(b) *GRANTS FOR MAINTENANCE AND RECRUITING.*—[ELIGIBILITY]

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

(2) *REQUIREMENTS.*—Grants may only be made under this section to a community college which—

(A) is accredited[,]*;*

(B) has *a relationship with* [access to] a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals[,]*;*

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

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

(ii) stipulate certifications necessary to approved internship and field placement opportunities at *Indian Health Programs;* [service unit facilities of the Service or at tribal health facilities,]*;*

(D) has a qualified staff which has the appropriate certifications[, and]*;*

(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1) [of this section.]*; and*

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

(c) [AGREEMENTS AND T]*Technical* [a]*ASSISTANCE*

The Secretary shall encourage community colleges described in subsection (b)(2) [of this section] to establish and maintain programs described in subsection (a)(1) [of this section] by—

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

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

(d) ADVANCED TRAINING

(*1*) *REQUIRED.*—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

(A)[(1)] has already received a degree or diploma in such health profession[,]*;* and

(B)[(2)] provides clinical services on *or near a* [an Indian] reservation *or for an Indian Health Program*[, at a Service facility, or at a tribal clinic].

(2) MAY BE OFFERED AT ALTERNATE SITE.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C) [of this section].

(e) FUNDING PRIORITY.—Where the requirements of subsection (b) are met, funding priority shall be provided to tribal colleges and universities in Service Areas where they exist.

[(e) DEFINITIONS

[For purposes of this section

[(1) The term "community college" means—

[(A) a tribally controlled community college, or

[(B) a junior or community college.

[(2) The term "tribally controlled community college" has the meaning given to such term by section 1801(4) of this title.

[(3) The term "junior or community college" has the meaning given to such term by section 1058(e) of Title 20.

[§ 1616i. Additional incentives for health professionals

[(a) INCENTIVE SPECIAL PAY

[The Secretary may provide the incentive special pay authorized under section 302(b) of Title 37, to civilian medical officers of the Indian Health Service who are assigned to, and serving in, positions included in the list established under subsection (b)(1) of this section for which recruitment or retention of personnel is difficult.

[(b) LIST OF POSITIONS; BONUS PAY

[(1) the Secretary shall establish and update on an annual basis a list of positions of health care professionals employed by, or assigned to, the Service for which recruitment or retention is difficult.

[(2)(A) The Secretary may pay a bonus to any commissioned officer or civil service employee, other than a commissioned medical officer, dental officer, optometrist, and veterinarian, who is employed in or assigned to, and serving in, a position in the Service included in the list established by the Secretary under paragraph (1).

[(B) The total amount of bonus payments made by the Secretary under this paragraph to any employee during any 1-year period shall not exceed $2,000.

[(c) WORK SCHEDULES

[The Secretary may establish programs to allow the use of flexible work schedules, and compressed work schedules, in accordance with the provisions of subchapter II of chapter 61 of Title 5, for health professionals employed by, or assigned to, the Service.]

§ 1616j. Retention bonus

(a) *BONUS AUTHORIZED.*—[ELIGIBILITY]

The Secretary may pay a retention bonus to any *health professional* [physician or nurse] employed by, or assigned to, and serving in, *an Indian Health Program or Urban Indian Organization* [the Service] either as a civilian employee or as a commissioned

officer in the Regular or Reserve Corps of the Public Health Service who—

(1) is assigned to, and serving in, a position [included in the list established under section 1616i(b)(1) of this title] for which recruitment or retention of personnel is difficult[,]*;*

(2) the Secretary determines is needed by *Indian Health Programs and Urban Indian Organizations;* [the Service,]

(3) has—

(A) completed 3 years of employment with *an Indian Health Program or Urban Indian Organization;* [the Service,] or

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

(i) any Federal scholarship program[,]*;* or

(ii) any Federal education loan repayment program[,]*;* and

(4) enters into an agreement with *an Indian Health Program or Urban Indian Organization* [the Service] for continued employment for a period of not less than 1 year.

[(b) MINIMUM AWARD PERCENTAGE TO NURSES

[Beginning with fiscal year 1993, not less than 25 percent of the retention bonuses awarded each year under subsection (a) of the section shall be awarded to nurses.]

(*b*)[(c)] RATES.—[; MAXIMUM RATE]

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

[(d) TIME OF PAYMENT

[The retention bonus for the entire period covered by the agreement described in subsection (a)(4) of this section shall be paid at the beginning of the agreed upon term of service.

[(e) REFUND; INTEREST]

(c) DEFAULT OF RETENTION AGREEMENT.—

Any *health professional* [physician or nurse] failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section *110(l)(2)(B)* [1616a(l)(2)(B) of this title].

(d) OTHER RETENTION BONUS.—

[(f) PHYSICIANS AND NURSES EMPLOYED UNDER INDIAN SELF-DETERMINATION ACT]

The Secretary may pay a retention bonus to any *health professional* [physician or nurse] employed by *a Tribal Health Program* [an organization providing health care services to Indians pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et. Seq.]] if such *health professional* [physician or nurse] is serving in a position which the Secretary determines is—

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

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

§ 1616k. Nursing residency program

(a) ESTABLISHMENT *OF PROGRAM*.—

The Secretary, acting through the Service, shall establish a program to enable *Indians who are* licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian *H*[h]ealth *P*[p]rogram *or Urban Indian Organization* [(as defined in section 1616a(a)(2)(A) of this title)], and have done so for a period of not less than *1* [one] year, to pursue advanced training.

[(b) PROGRAM COMPONENTS]

Such program shall include a combination of education and work study in an Indian *H*[h]ealth *P*[p]rogram *or Urban Indian Organization* [(as defined in section 1616a(a)(2)(A) of this title)] leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse), [or] a bachelor's degree (in the case of a registered nurse) or *advanced degrees or certification in nursing and public health* [a Master's degree].

(b)[(c)] SERVICE *O*[O]BLIGATION.—[OF PROGRAM PARTICIPANT]

An individual who participates in a program under subsection (a) [of this section], where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian *H*[h]ealth *P*[p]rogram *or Urban Indian Organization* for a period of obligated service equal to *the amount of* [at least three times the period of the] time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (*l*) of section *110* [1616a of this title] in the manner provided for in such subsection.

§ 1616*l*. Community Health Aide Program for Alaska

(a) *GENERAL PURPOSES* [MAINTENANCE] OF PROGRAM.—

Under the authority of *the Act of November 2, 1921 (25 U.S.C. 13)(commonly known as the 'Snyder Act')* [section 13 of this title], the Secretary, *acting through the Service*, shall *develop and operate* [maintain] a Community Health Aide Program in Alaska under which the Service—

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

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

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

(b) *SPECIFIC PROGRAM REQUIREMENTS*.—[TRAINING; CURRICULUM; CERTIFICATION BOARD]

The Secretary, acting through the Community Health Aide Program of the Service, shall—

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

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

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

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

(C) promotes the achievement of the health status objectives specified in section *3(2)* [1602(b) of this title];

(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

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

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

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

(c) NATIONAL COMMUNITY HEALTH AIDE PROGRAM.—The Secretary, acting through the Service, shall develop and promulgate regulations to operate a national Community Health Aide Program consistent with the requirements of this section without reducing funds for the Community Health Aide Program for Alaska.

[§ 1616m. Matching grants to tribes for scholarship programs

[(a) IN GENERAL

[(1) The Secretary shall make grants to Indian tribes and tribal organizations for the purpose of assisting such tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

[(2) Amounts available for grants under paragraph (1) for any fiscal year shall not exceed 5 percent of amounts available for such fiscal year for Indian Health Scholarships under section 1613a of this title.

[(3) An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as the Secretary determines are necessary to carry out this section.

[(b) COMPLIANCE WITH REQUIREMENTS

[(1) An Indian tribe or tribal organization receiving a grant under subsection (a) of this section shall agree to provide scholarships to Indians pursuing education in the health professions in accordance with the requirements of this section.

[(2) With respect to the costs of providing any scholarship pursuant to paragraph (1)—

[(A) 80 percent of the costs of the scholarship shall be paid from the grant made under subsection (a) of this section to the Indian tribe or tribal organization; and

[(B) 20 percent of such costs shall be paid from non-Federal contributions by the Indian tribe or tribal organization through which the scholarship is provided.

[(3) In determining the amount of non-Federal contributions that have been provided for purposes of subparagraph (B) of paragraph (2), any amounts provided by the Federal Government to the Indian tribe or tribal organization involved or to any other entity shall not be included.

[(4) Non-Federal contributions required by subparagraph (B) of paragraph (2) may be provided directly by the Indian tribe or tribal organization involved or through donations from public and private entities.

[(c) COURSE OF STUDY IN HEALTH PROFESSIONS

[An Indian tribe or tribal organization shall provide scholarships under subsection (b) of this section only to Indians enrolled or accepted for enrollment in the course of study (approved by the Secretary) in one of the health professions described in section 1613a(a) of this title.

[(d) CONTRACT REQUIREMENTS

[In providing scholarships under subsection (b) of this section, the Secretary and the Indian tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

[(1) obligate such recipient to provide service in an Indian health program (as defined in section 1616a(a)(2)(A) of this title), in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—

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

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

[(2) provide that the amount of such scholarship—

[(A) may be expended only for—

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

[(ii) payment to the recipient of a monthly stipend of not more than the amount authorized by section 254*l*(g)(1)(B) of Title 42, such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled; and

[(B) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in subparagraph (A);

[(3) require the recipient of such scholarship to maintain an acceptable level of academic standing (as determined by the

educational institution in accordance with regulations issued by the Secretary); and

[(4) require the recipient of such scholarship to meet the educational and licensure requirements necessary to be a physician, certified nurse practitioner, certified nurse midwife, or physician assistant.

[(e) BREACH OF CONTRACT

[(1) an individual who has entered into a written contract with the Secretary and an Indian tribe or tribal organization under subsection (d) of this section and who—

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

[(B) is dismissed from such educational institution for disciplinary reasons,

[(C) voluntarily terminates the training in such an educational institution for which he is provided a scholarship under such contract before the completion of such training, or

[(D) fails to accept payment, or instructs the educational institution in which he is enrolled not to accept payment,

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

[(2) If for any reason not specified in paragraph (1), an individual breaches his written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (*l*) of section 1616a of this title in the manner provided for in such subsection.

[(3) The Secretary may carry out this subsection on the basis of information submitted by the tribes or tribal organization involved, or on the basis of information collected through such other means as the Secretary determines to be appropriate.

[(f) NONDISCRIMINATORY PRACTICE

[The recipient of a scholarship under subsection (b) of this section shall agree, in providing health care pursuant to the requirements of subsection (d)(1) of this section—

[(1) not to discriminate against an individual seeking such care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in title XVIII of the Social Security Act [42 U.S.C.A. § 1395 et. Seq.] or pursuant to the program established in title XIX of such Act [42 U.S.C.A. § 1396 et. seq.]; and

[(2) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act [42 U.S.C.A. § 1395u(b)(3)(B)(ii)] for all services for which payment may be made under part B of title XVIII of such Act [42 U.S.C.A. § 1395j et. seq.], and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX

of such Act [42 U.S.C.A. § 1396 et. seq.] to provide service to individuals entitled to medical assistance under the plan.

[(g) PAYMENTS FOR SUBSEQUENT FISCAL YEARS

[The Secretary may not make any payments under subsection (a) of this section to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has complied with requirements of this section.]

§ 1616n. Tribal *H*[h]ealth *P*[p]rogram *A*[a]dministration

The Secretary, *acting through the Service,* shall, by *funding agreement* [contract] or otherwise, provide training for *Indians* [individuals] in the administration and planning of *T*[t]ribal *H*[h]ealth *P*[p]rograms.

§ 123. Health Professional Chronic Shortage Demonstration Programs

(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—

(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

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

(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region.

(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

§ 124. Treatment of Scholarships for Certain Purposes

Scholarships provided to individuals pursuant to this title shall be deemed 'qualified Scholarships' for purposes of section 11 of the Internal Revenue Code of 1986.

§ 125. National Health Service Corps

(a) NO REDUCTION IN SERVICES.—The Secretary shall not—

(1) remove a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization; or

(2) withdraw funding used to support such member;

unless the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations, has ensured that the Indians receiving services from such member will experience no reduction in services.

(b) EXEMPTION FROM LIMITATIONS.—National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the

Service when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

§ 126. Substance Abuse Counselor Educational Curricula Demonstration Programs

(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.

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

(c) TIME PERIOD OF ASSISTANCE; RENEWAL.—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1-year period upon the approval of the Secretary.

(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—Not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

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

(f) REPORT.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

(g) DEFINITION.—For the purposes of this section, the term 'educational curriculum' means 1 or more of the following:

(1) Classroom education.

(2) Clinical work experience.

(3) Continuing education workshops.

§ 127. Behavioral Health Training and Community Education Programs

(a) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self destructive behavior.

(b) POSITIONS.—The positions referred to in subsection (a) are—

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

(A) elementary and secondary education;

(B) social services and family and child welfare;

(C) law enforcement and judicial services; and

(D) alcohol and substance abuse;

(2) staff positions within the Service; and

(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations, (without regard to the funding source) and Urban Indian Organizations.

(c) TRAINING CRITERIA.—

(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or Urban Indian Organization for training of appropriate individuals. In the case of positions funded under a funding agreement, the appropriate Secretary shall ensure that funds to cover the costs of such training costs are included in the funding agreement.

(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding Traditional Health Care Practices is provided.

(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, or assist the Indian Tribe, Tribal Organization, or Urban Indian Organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

(e) PLAN.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of the enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act').

[§ 1616o. University of South Dakota pilot program

[(a) ESTABLISHMENT

[The Secretary may make a grant to the School of Medicine of the University of South Dakota (hereafter in this section referred to as "USDSM") to establish a pilot program on an Indian reserva-

tion at one or more service units in South Dakota to address the chronic manpower shortage in the Aberdeen Area of the Service.

[(b) PURPOSES

[The purposes of the program established pursuant to a grant provided under subsection (a) of this section are—

[(1) to provide direct clinical and practical experience at the service unit to medical students and residents from USDSM and other medical schools;

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

[(3) to provide academic and scholarly opportunities for physicians, physician assistants, nurse practitioners, nurse, and other allied health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

[(c) COMPOSITION; DESIGNATION

[The pilot program established pursuant to a grant provided under subsection (a) of this section shall—

[(1) incorporate a program advisory board composed of representatives from the tribes and communities in the area which will be served by the program; and

[(2) shall be designated as an extension of the USDSM campus and program participants shall be under the direct supervision and instruction of qualified medical staff serving at the service unit who shall be members of the USDSM faculty.

[(d) COORDINATION WITH OTHER SCHOOLS

[The USDSM shall coordinate the program established pursuant to a grant provided under subsection (a) of this section with other medical schools in the region, nursing schools, tribal community colleges, and other health professional schools.

[(e) DEVELOPMENT OF ADDITIONAL PROFESSIONAL OPPORTUNITIES

[The USDSM, in cooperation with the Service, shall develop additional professional opportunities for program participants on Indian reservations in order to improve the recruitment and retention of qualified health professionals in the Aberdeen Area of the Service.]

§ 1616p. Authorization of [a]*Appropriations*

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* [2000] to carry out this *title* [subchapter].

TITLE [SUBCHAPTER] II—HEALTH SERVICES

§ 1621. Indian Health Care Improvement Fund

(a) *USE OF FUNDS*.—[APPROVED EXPENDITURES]

The Secretary, *acting through the Service,* is authorized to expend funds, *directly or under the authority of the Indian Self-Determination and Education Assistance Act,* which are appropriated under the authority of this section, [through the Service,] for the purposes of—

(1) eliminating the deficiencies in health status and *health resources* of all Indian [t]*T*ribes[,]*;*

(2) eliminating backlogs in the provision of health care services to Indians[,]*;*

(3) meeting the health needs of Indians in an efficient and equitable manner, *including the use of telehealth and telemedicine when appropriate;* [and]

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

(5)[(4)] augmenting the ability of the Service to meet the following health service responsibilities[, either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.],] with respect to those Indian [t]*T*ribes with the highest levels of health status *deficiencies* and resource deficiencies:

(A) [c]*C*linical care, [(direct and indirect)] including, *but not limited to, inpatient care, outpatient care (including audiology,* clinical eye and vision care*), primary care, secondary and tertiary care, and long-term care.*[;]

(B) [p]*P*reventive health, including [screening] mammography *and other cancer screening* in accordance with section *207.* [1621k of this title;]

(C) [d]*D*ental care. [(direct and indirect);]

(D) [m]*M*ental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional *health care* [Indian] practitioners.[;]

(E) [e]*E*mergency medical services.[;]

(F) [t]*T*reatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians.[;]

(G) [a]*A*ccident prevention programs.[;]

(H) [h]*H*ome health care.[;]

(I) [c]*C*ommunity health representatives.[; and]

(J) [m]*M*aintenance and repair.

(K) Traditional Health Care Practices.

(b) *NO OFFSET OR LIMITATION.*—[EFFECT ON OTHER APPROPRIATIONS; ALLOCATION TO SERVICE UNITS]

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

(c) ALLOCATION; USE.—[(2)(A)]

(1) IN GENERAL.—Funds appropriated under the authority of this section *shall* [may] be allocated to *Service Units, Indian Tribes, or Tribal Organizations* [on a service unit basis]. The funds allocated to each *Indian Tribe, Tribal Organization, or S*[s]ervice *U*[u]nit under this [sub]paragraph shall be used by the *Indian Tribe, Tribal Organization, or S*[s]ervice *U*[u]nit *under this paragraph to improve* [reduce] the health status and *reduce the resource deficiency of each Indian tribe* served by such *S*[s]ervice *U*[u]nit, *Indian Tribe, or Tribal Organization.*

(2)[(B)] *APPORTIONMENT OF ALLOCATED FUNDS.*—The apportionment of funds allocated to a *S*[s]ervice *U*[u]nit, *Indian*

Tribe, or Tribal Organization under [sub]paragraph *(1)*[(A)] among the health service responsibilities described in subsection (a)*(5)*[(4) of this section] shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes *and Tribal Organizations.*

(d)[(c)] *PROVISIONS RELATING TO* HEALTH *STATUS AND R*[R]ESOURCE[S D]*D*EFICIENC[Y]*IES* [LEVELS]

For purposes of this section, *the following definitions apply:*[—]

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

(A) the health status objectives set forth in section 3*(2)*[1602(b) of this title] are not being achieved; and

(B) the Indian [t]*T*ribe *or Tribal Organization* does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) *AVAILABLE RESOURCES.*—The health resources available to an Indian [t]*T*ribe *or Tribal Organization* include health resources provided by the Service as well as health resources used by the Indian [t]*T*ribe *or Tribal Organization,* including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

(3) *PROCESS FOR REVIEW OF DETERMINATIONS.*—The Secretary shall establish procedures which allow any Indian [t]*T*ribe *or Tribal Organization* to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such *Indian T*[t]ribe *or Tribal Organization.*

(e)[(d)] *ELIGIBILITY FOR FUNDS.*—[PROGRAMS ADMINISTERED BY INDIAN TRIBE]

[(1)] *Tribal Health* Programs [administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination Act] shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

[(2) If any funds allocated to a tribe or service unit under the authority of this section are used for a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], a reasonable portion of such funds may be used for health planning, training, technical assistance, and other administrative support functions.]

(f)[(e)] REPORT [TO CONGRESS].—

By no later than the date that is 3 years after *the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004* [October 29, 1992], the Secretary shall submit to [the] Congress the current health status and resource deficiency report of the Service for each [Indian tribe or s]*S*ervice [u]*U*nit, including newly recognized or acknowledged *Indian T*[t]ribes. Such report shall set out—

(1) the methodology then in use by the Service for determining [t]*T*ribal health status and resource deficiencies, as well as the most recent application of that methodology;

(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service *or a Tribal Health Program;*

(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service *or a Tribal Health Program;* and

(4) an estimate of—

(A) the amount of health service funds appropriated under the authority of this *Act* [chapter], or any other Act, including the amount of any funds transferred to the Service[,] for the preceding fiscal year which is allocated to each *S*[s]ervice *U*[u]nit, Indian [t]*T*ribe, *or Tribal Organization* [comparable entity];

(B) the number of Indians eligible for health services in each [s]*S*ervice [u]*U*nit or Indian [t]*T*ribe *or Tribal Organization*; and

(C) the number of Indians using the Service resources made available to each [s]*S*ervice [u]*U*nit, [or] Indian [t]*T*ribe *or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.*

(g)[(f)] *INCLUSION* [APPROPRIATED FUNDS INCLUDED] IN [B]*BASE* [B]*B*UDGET [OF SERVICE].—

Funds appropriated under [authority of] this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

(h)[(g)] *CLARIFICATION.*—[CONTINUATION OF SERVICE RESPONSIBILITIES FOR BACKLOGS AND PARITY]

Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to discourage the Service from undertaking additional efforts to achieve *equity* [parity] among Indian[s t]*T*ribes *and Tribal Organizations.*

(i)[(h)] *FUNDING DESIGNATION.*—[AUTHORIZATION OF APPROPRIATIONS]

Any funds appropriated under the authority of this section shall be designated as the ["]'Indian Health Care Improvement Fund'["].

§ 1621a. Catastrophic [h]*H*ealth [e]*E*mergency [f]*F*und

(a) ESTABLISHMENT.—[; ADMINISTRATION; PURPOSE]

[(1)] There is hereby established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the *'CHEF'* ["Fund"]) consisting of—

(1)[(A)] the amounts deposited under subsection *(f)*[(d) of this section,]*;* and

(2)[(B)] the amounts appropriated to *CHEF* [the Fund] under this section.

(b) ADMINISTRATION.—[(2) The Fund] *CHEF* shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

[(3) The Fund shall not be allocated, apportioned, or delegated on a service unit, area office, or any other basis.]

(c) CONDITIONS ON USE OF FUND.—[(4)] No part of *CHEF* [the Fund] or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination *and Education Assistance Act,*[[25 U.S.C.A. §450f et seq.].] *nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.*

(d)[(b)] REGULATIONS.—[; PROCEDURES FOR PAYMENT]

The Secretary shall, through the *negotiated rulemaking process under title VIII, promulgate* [promulgation of] regulations consistent with the provisions of this section to—

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

(2) provide that a [s]*S*ervice [u]*U*nit shall not be eligible for reimbursement for the cost of treatment from *CHEF* [the Fund] until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

(A) *the 2000 level of $19,000* [for 1993, not less than $15,000 or not more than $25,000]; and

(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

(3) establish a procedure for the reimbursement of the portion of the costs *that exceeds such threshold cost* incurred by—

(A) [s]*S*ervice [u]*U*nits*;* [or facilities of the Service,] or

(B) whenever otherwise authorized by the Service, non-Service facilities or providers[, in rendering treatment that exceeds such threshold cost];

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

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

(e) NO OFFSET OR LIMITATION.—[(c) EFFECT ON OTHER APPROPRIATIONS]

Amounts appropriated to *CHEF* [the Fund] under this section shall not be used to offset or limit appropriations made to the Service under authority of *the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act')* [section 13 of this title], or any other law.

(f)[(d)] *DEPOSIT OF* REIMBURSEMENT[S TO] FUNDS.—

There shall be deposited into *CHEF* [the Fund] all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason

of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from *CHEF* [the Fund].

§ 1621b. Health [p]*P*romotion and [d]*D*isease [p]*P*revention [s]*S*ervices

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

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

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

[(a) AUTHORIZATION]

(b) PROVISION OF SERVICES.—

The Secretary, acting through the Service *and Tribal Health Programs*, shall provide health promotion and disease prevention services to Indians [so as] to achieve the health status objectives set forth in section *3(2)*[1602(b) of this title].

(c)[(b)] EVALUATION.—[STATEMENT FOR PRESIDENTIAL BUDGET]

The Secretary, *after obtaining input from the affected Tribal Health Programs,* shall submit to the President for inclusion in each *report* [statement] which is required to be submitted to [the] Congress under section *801*[1671 of this title] an evaluation of—

(1) the health promotion and disease prevention needs of Indians[,]*;*

(2) the health promotion and disease prevention activities which would best meet such needs[,]*;*

(3) the internal capacity of the Service *and Tribal Health Programs* to meet such needs[,]*;* and

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

§ 1621c. Diabetes [p]*P*revention, [t]*T*reatment, and [c]*C*ontrol

(a) *DETERMINATIONS REGARDING DIABETES.*—[INCIDENCE AND COMPLICATIONS]

The Secretary, *acting through the Service, and* in consultation with [the] *Indian T*[t]ribes *and Tribal Organizations*, shall determine—

(1) by *an Indian T*[t]ribe, *Tribal Organization,* and by Service [u]*U*nit [of the Service], the incidence of, and the types of complications resulting from, diabetes among Indians; and

(2) based on *the determinations made pursuant to* paragraph (1), the measures (including patient education *and effective ongoing monitoring of disease indicators*) each Service [u]*U*nit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among *Indian T*[t]ribes within that Service unit.

(b) *DIABETES SCREENING.*—

To the extent medically indicated and with informed consent, t[T]he Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic *and, in consultation with Indian Tribes, Urban Indian Organizations, and appropriate health care providers, establish a cost-effective approach to ensure ongoing monitoring of disease indicators.* Such screening

and monitoring may be *conducted* [done] by a *Tribal Health Program and may be conducted through appropriate Internet-based health care management programs.* [tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].]

(c) FUNDING FOR DIABETES.—The Secretary shall continue to fund each model diabetes project in existence on the date of the enactment of the Indian Health Care Improvement Amendments Act of 2004, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian Tribes. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2004 and for projects which are added and funded thereafter.

[(c) MODEL DIABETES PROJECTS

[(1) The Secretary shall continue to maintain through fiscal year 2000 each model diabetes project in existence October 29, 1992 and located—

[(A) at the Claremore Indian Hospital in Oklahoma;

[(B) at the Fort Totten Health Center in North Dakota;

[(C) at the Sacaton Indian Hospital in Arizona;

[(D) at the Winnebago Indian Hospital in Nebraska;

[(E) at the Albuquerque Indian Hospital in New Mexico;

[(F) at the Perry, Princeton, and Old Town Health Centers in Maine;

[(G) at the Bellingham Health Center in Washington;

[(H) at the Fort Berthold Reservation;

[(I) at the Navajo Reservation;

[(J) at the Papago Reservation;

[(K) at the Zuni Reservation; or

[(L) in the States of Alaska, California, Minnesota, Montana, Oregon, or Utah.

[(2) The Secretary may establish new model diabetes projects under this section taking into consideration applications received under this section from all service areas, except that the Secretary may not establish a greater number of such projects in one service area than in any other service area until there is an equal number of such projects established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).]

(d) FUNDING FOR DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian Tribes, and Tribal Organizations to establish dialysis programs, including funding to purchase dialysis equipment and provide necessary staffing.

[(d) CONTROL OFFICER; REGISTRY OF PATIENTS

[The Secretary shall—

[(1) employ in each area office of the Service at least one diabetes control officer who shall coordinate and manage on a full-time basis activities within that area office for the prevention, treatment, and control of diabetes;

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

[(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to all other area offices; and

[(4) evaluate the effectiveness of services provided through model diabetes projects established under this section.]

(e) OTHER DUTIES OF THE SECRETARY.—The Secretary shall, to the extent funding is available—

(1) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

(2) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

(3) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

[(e) AUTHORIZATION OF APPROPRIATIONS

[Funds appropriated under this section in any fiscal year shall be in addition to base resources appropriated to the Service for that year.]

§ 205. Shared Services for Long-Term Care

(a) FUNDING AGREEMENTS FOR LONG-TERM CARE.—Notwithstanding any other provisions of law, the Secretary, acting through the Service, 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 funding agreements or other arrangements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or other similar facility owned and operated (directly or through a Funding Agreement) by such Indian Tribe or Tribal Organization.

(b) CONTENTS OF FUNDING AGREEMENTS.—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 Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

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

(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

[§ 1621d. Hospice care feasibility study

[(a) DUTY OF SECRETARY

[The Secretary, acting through the Service and in consultation with representatives of Indian tribes, tribal organizations, Indian Health Service personnel, and hospice providers, shall conduct a study—

[(1) to assess the feasibility and desirability of furnishing hospice care to terminally ill Indians; and

[(2) to determine the most efficient and effective means of furnishing such care.

[(b) FUNCTIONS OF STUDY

[Such study shall—

[(1) assess the impact of Indian culture and beliefs concerning death and dying on the provision of hospice care to Indians;

[(2) estimate the number of Indians for whom hospice care may be appropriate and determine the geographic distribution of such individuals;

[(3) determine the most appropriate means to facilitate the participation of Indian tribes and tribal organizations in providing hospice care;

[(4) identify and evaluate various means for providing hospice care, including—

[(A) the provision of such care by the personnel of a Service hospital pursuant to a hospice program established by the Secretary at such hospital; and

[(B) the provision of such care by a community-based hospice program under contract to the Service; and

[(5) identify and assess any difficulties in furnishing such care and the actions needed to resolve such difficulties.

[(c) REPORT TO CONGRESS

[Not later than the date which is 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report containing—

[(1) a detailed description of the study conducted pursuant to this section; and

[(2) a discussion of the findings and conclusions of such study.

[(d) DEFINITIONS

[For the purposes of this section—

[(1) the term "terminally ill" means any Indian who has a medical prognosis (as certified by a physician) of a life expectancy of six months or less; and

[(2) the term "hospice program" means any program which satisfies the requirements of section 1395x(dd)(2) of Title 42; and

[(3) the term "hospice care" means the items and services specified in subparagraphs (A) through (H) of section 1395x(dd)(1) of Title 42.]

§ 206. Health Services Research

The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs and shall coordinate the activities of other agencies within the Department to address these research needs. Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section. This funding may be used for both clinical and non-clinical research.

[§ 1621e. Reimbursement from certain third parties of costs of health services

[(a) RIGHT OF RECOVERY

[Except as provided in subsection (f) of this section, the United States, an Indian tribe, or a tribal organization shall have the right to recover the reasonable expenses incurred by the Secretary, an Indian tribe, or a tribal organization in providing health services, through the Service, an Indian tribe, or tribal organization, to any individual to the same extent that such individual, or any non-governmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—

[(1) such services had been provided by a nongovernmental provider, and

[(2) such individual had been required to pay such expenses and did pay such expenses.

[(b) RECOVERY AGAINST STATE WITH WORKERS' COMPENSATION LAWS OR NO-FAULT AUTOMOBILE ACCIDENT INSURANCE PROGRAM

[Subsection (a) of this section shall provide a right of recovery against any State only if the injury, illness, or disability for which health services were provided is covered under—

[(1) workers' compensation laws, or

[(2) a no-fault automobile accident insurance plan or program.

[(c) PROHIBITION OF STATE LAW OR CONTRACT PROVISION IMPEDING RIGHT OF RECOVERY

[No law of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of the United States, an Indian tribe, or a tribal organization under subsection (a) of this section.

[(d) RIGHT TO DAMAGES

[No action taken by the United States, an Indian tribe, or a tribal organization to enforce the right of recovery provided under subsection (a) of this section shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

[(e) INTERVENTION OR SEPARATE CIVIL ACTION

[The United States, an Indian tribe, or a tribal organization may enforce the right of recovery provided under subsection (a) of this section by—

[(1) intervening or joining in any civil action or proceeding brought—

[(A) by the individual for whom health services were provided by the Secretary, an Indian tribe, or a tribal organization, or

[(B) by any representative or heirs of such individual, or

[(2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, an Indian tribe, or a tribal organization to institute a separate civil action.

[(f) RIGHT OF RECOVERY FOR SERVICES WHEN SELF-INSURANCE PLAN PROVIDES COVERAGE

[The United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.]

§ 207. Mammography and Other Cancer Screening

The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:

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

(2) Other cancer screening meeting national standards, such as those of the National Cancer Institute.

[§ 1621f. Crediting of reimbursements

[(a) Except as provided in section 1621a(d) of this title, subchapter III–A of this chapter, and section 1680c of this title, all reimbursements received or recovered, under authority of this chapter, Public Law 87–693 (42 U.S.C. 2651, et seq.), or any other provision of law, by reason of the provision of health services by the Service or by a tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

[(b) The Service may not offset or limit the amount of funds obligated to any service unit or any entity under contract with the Service because of the receipt of reimbursements under subsection (a) of this section.]

§ 208. Patient Travel Costs

The Secretary, acting through the Service and Tribal Health Programs, 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) under this Act—

(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

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

[§ 1621g. Health services research

[Of the amounts appropriated for the Service in any fiscal year, other than amounts made available for the Indian Health Care Improvement Fund, not less than $200,000 shall be available only for research to further the performance of the health service responsibilities of the Service. Indian tribes and tribal organizations contracting with the Service under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be given an equal opportunity to compete for, and receive, research funds under this section.**]**

§ 209. Epidemiology Centers

(a) ADDITIONAL CENTERS.—In addition to those epidemiology centers already established at the time of enactment of this Act, (including those for which funding is currently being provided in Funding Agreements), and without reducing the funding levels for such centers, not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary, acting through the Service, shall establish and fund an epidemiology center in each Service Area which does not yet have one to carry out the functions described in subsection (b). Any new centers so established may be operated by Tribal Health Programs, but such funding shall not be divisible.

(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each Service Area epidemiology center established under this subsection shall, with respect to such Service Area—

(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the Service Area;

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

(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

(4) make recommendations for the targeting of services needed by the populations served;

(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

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

(d) FUNDING FOR STUDIES.—The Secretary may make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct epidemiological studies of Indian communities.

[§ 1621h. Mental health prevention and treatment services

[(a) NATIONAL PLAN FOR INDIAN MENTAL HEALTH SERVICES

[(1) Not later than 120 days after November 28, 1990, the Secretary, acting through the Service, shall develop and publish in the Federal Register a final national plan for Indian Mental Health Services. The plan shall include—

[(A) an assessment of the scope of the problem of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians, including—

[(i) the number of Indians served by the Service who are directly or indirectly affected by such illness or behavior, and

[(ii) an estimate of the financial and human cost attributable to such illness or behavior;

[(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior; and

[(C) an estimate of the additional funding needed by the Service to meet its responsibilities under the plan.

[(2) The Secretary shall submit a copy of the national plan to the Congress.

[(b) MEMORANDUM OF AGREEMENT

[Not later than 180 days after November 28, 1990, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement under which the Secretaries shall, among other things—

[(1) determine and define the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

[(2) make an assessment of the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

[(3) make an initial determination of the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

[(4)(A) ensure that Indians, as citizens of the United States and of the States in which they reside, have access to mental health services to which all citizens have access;

[(B) determine the right of Indians to participate in, and receive the benefit of, such services; and

[(C) take actions necessary to protect the exercise of such right;

[(5) delineate the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

[(6) provide a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

[(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) [25 U.S.C.A. § 2401 et seq.] with the mental health initiatives pursuant to this chapter, particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and

[(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

[(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to subsection (d) of this section; and

[(8) provide for an annual review of such agreement by the two Secretaries.

[(c) COMMUNITY MENTAL HEALTH PLAN

[(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a community mental health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members.

[(2) In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the tribe in the development of such plan. Upon the establishment of such a plan and at the request of the tribe, such officials, as directed by the memorandum of agreement developed pursuant to subsection (c), of this section, shall cooperate with the tribe in the implementation of such plan.

[(3) Two or more Indian tribes may form a coalition for the adoption of resolutions and the establishment and development of a joint community mental health plan under this subsection.

[(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community mental health plan and to provide administrative support in the implementation of such plan.

[(d) MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS

[(1) The Secretary and the Secretary of the Interior, in consultation with representatives of Indian tribes, shall conduct a study and compile a list, of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness or dysfunctional and self-destructive behavior.

[(2) The positions referred to in paragraph (1) are—

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

[(i) elementary and secondary education;

[(ii) social services and family and child welfare;

[(iii) law enforcement and judicial services; and

[(iv) alcohol and substance abuse;

[(B) staff positions with the Service; and

[(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes, including positions established in contracts entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.].

[(3)(A) The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraph (2)(A) and ensure that appropriate training has been, or will be, provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to an Indian tribe for the training of, such individual. In the case of positions funded under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], the appropriate Secretary shall ensure that such training costs are included in the contract, if necessary.

[(B) Funds authorized to be appropriated pursuant to this section may be used to provide training authorized by this paragraph for community education programs described in paragraph (5) if a plan adopted pursuant to subsection (d) of this section identifies individuals or employment categories, other than those identified pursuant to paragraph (1), for which such training or community education is deemed necessary or desirable.

[(4) Position-specific training criteria described in paragraph (3) shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional Indian healing and treatment practices is provided.

[(5) The Service shall develop and implement or, upon the request of an Indian tribe, assist such tribe to develop and implement, a program of community education on mental illness and dysfunctional and self-destructive behavior for individuals, as determined in a plan adopted pursuant to subsection (d) of this section. In carrying out this paragraph, the Service shall provide, upon the request of an Indian tribe, technical assistance to the Indian tribe to obtain or develop community education and training materials on the identification, prevention,

referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

[(e) STAFFING

[(1) Within 90 days after November 28, 1990, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within five years after November 28, 1990, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level for services which shall include outpatient, emergency, aftercare and follow-up, and prevention and education services.

[(2) The plan developed under paragraph (1) shall be implemented under section 13 of this title.

[(f) STAFF RECRUITMENT AND RETENTION

[(1) The Secretary shall provide for the recruitment of the additional personnel required by subsection (f) of this section and the retention of all Service personnel providing mental health services. In carrying out this subsection, the Secretary shall give priority to practitioners providing mental health services to children and adolescents with mental health problems.

[(2) In carrying out paragraph (1), the Secretary shall develop a program providing for—

[(A) the payment of bonuses (which shall not be more favorable than those provided for under section 1616i and 1616j of this title) for service in hardship posts;

[(B) the repayment of loans (for which the provisions of repayment contracts shall not be more favorable than the repayment contracts under section 1616a of this title) for health professions education as a recruitment incentive; and

[(C) a system of postgraduate rotations as a retention incentive.

[(3) This subsection shall be carried out in coordination with the recruitment and retention programs under subchapter I of this chapter.

[(g) MENTAL HEALTH TECHNICIAN PROGRAM

[(1) Under the authority of section 13 of this title, the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

[(A) provides for the training of Indians as mental health technicians; and

[(B) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

[(2) In carrying out paragraph (1)(A), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

[(3) The Secretary shall supervise and evaluate the mental health technicians in the training program.

[(4) The Secretary shall ensure that the program established pursuant to this subsection involves the utilization and promotion of the traditional Indian health care and treatment practices of the Indian tribes to be served.

[(h) MENTAL HEALTH RESEARCH

[The Secretary, acting through the Service and in consultation with the National Institute of Mental Health, shall enter into contracts with, or make grants to, appropriate institutions for the conduct of research on the incidence and prevalence of mental disorders among Indians on Indian reservations and in urban areas. Research priorities under this subsection shall include—

[(1) the inter-relationship and inter-dependence of mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence, and

[(2) the development of models of prevention techniques.

[The effect of the inter-relationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.

[(i) FACILITIES ASSESSMENT

[Within one year after November 28, 1990, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

[(j) ANNUAL REPORT

[The Service shall develop methods for analyzing and evaluating the overall status of mental health programs and services for Indians and shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the mental health status of Indians which shall describe the progress being made to address mental health problems of Indian communities.

[(k) MENTAL HEALTH DEMONSTRATION GRANT PROGRAM

[(1) The Secretary, acting through the Service, is authorized to make grants to Indian tribes and inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs to deliver innovative community-based mental health services to Indians. The 25 percent tribal share of such cost may be provided in cash or through the provision of property or services.

[(2) The Secretary may award a grant for a project under paragraph (1) to an Indian tribe or inter-tribal consortium which meets the following criteria:

[(A) The project will address significant unmet mental health needs among Indians.

[(B) The project will serve a significant number of Indians.

[(C) The project has the potential to deliver services in an efficient and effective manner.

[(D) The tribe or consortium has the administrative and financial capability to administer the project.

[(E) The project will deliver services in a manner consistent with traditional Indian healing and treatment practices.

[(F) The project is coordinated with, and avoids duplication of, existing services.

[(3) For purposes of this subsection, the Secretary shall, in evaluating applications for grants for projects to be operated under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], use the same criteria that the Secretary uses in evaluating any other application for such a grant.

[(4) The Secretary may only award one grant under this subsection with respect to a service area until the Secretary has awarded grants for all service areas with respect to which the Secretary receives applications during the application period, as determined by the Secretary, which meet the criteria specified in paragraph (2).

[(5) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a report evaluating the effectiveness of the innovative community-based projects demonstrated pursuant to this subsection. Such report shall include findings and recommendations, if any, relating to the reorganization of the programs of the Service for delivery of mental services to Indians.

[(6) Grants made pursuant to this section may be expended over a period of three years and no grant may exceed $1,000,000 for the fiscal years involved.

[(*l*) LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS

[Any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this chapter or through a contract pursuant to the Indian Self-Determination Act [25 U.S.C.A. § 450f et. seq.] shall—

[(1) in the case of a person employed as a psychologist, be licensed as a clinical psychologist or working under the direct supervision of a licensed clinical psychologist;

[(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

[(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

[(m) INTERMEDIATE ADOLESCENT MENTAL HEALTH SERVICES

[(1) The Secretary, acting through the Service, may make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents, including—

[(A) inpatient and outpatient services;

[(B) emergency care;

[(C) suicide prevention and crisis intervention; and

[(D) prevention and treatment of mental illness, and dysfunctional and self-destructive behavior, including child abuse and family violence.

[(2) Funds provided under this subsection may be used—

[(A) to construct or renovate an existing health facility to provide intermediate mental health services;

[(B) to hire mental health professionals;

[(C) to staff, operate, and maintain an intermediate mental health facility, group home, or youth shelter where intermediate mental health services are being provided; and

[(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units.

[(3) Funds provided under this subsection may not be used for the purposes described in section 1621o(b)(1) of this title.

[(4) An Indian tribe or tribal organization receiving a grant under this subsection shall ensure that intermediate adolescent mental health services are coordinated with other tribal, Service, and Bureau of Indian Affairs mental health, alcohol and substance abuse, and social services programs on the reservation of such tribe or tribal organization.

[(5) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this subsection.

[(6) There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 210. Comprehensive Health Education Programs

(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—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 pre-school through grade 12 in schools for the benefit of Indian and Urban Indian children.

(b) USE OF FUNDS.—Funding provided under this section may be used for purposes which may include, but are not limited to, the following:

(1) Developing and implementing health education curricula both for regular school programs and afterschool programs.

(2) Training teachers in comprehensive school health education curricula.

(3) Integrating school-based, community-based, and other public and private health promotion efforts.

(4) Encouraging healthy, tobacco-free school environments.

(5) Coordinating school-based health programs with existing services and programs available in the community.

(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

(7) Developing behavioral health wellness programs.

(8) Developing chronic disease prevention programs.

(9) Developing substance abuse prevention programs.

(10) Developing injury prevention and safety education programs.

(11) Developing activities for the prevention and control or communicable diseases.

(12) Developing community and environmental health education programs that include traditional health care practitioners.

(13) Violence prevention.

(14) Such other health issues as are appropriate.

(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications for funding provided pursuant to this section.

(e) DEVELOPMENT OF PROGRAM FOR BIA FUNDED SCHOOLS.—

(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, and affected Indian Tribes and Tribal Organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include—

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

(B) behavioral health wellness programs;

(C) chronic disease prevention programs;

(D) substance abuse prevention programs;

(E) injury prevention and safety education programs; and

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

(3) DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—

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

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

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

[§ 1621i. Managed care feasibility study

[(a) The Secretary, acting through the Service, shall conduct a study to assess the feasibility of allowing an Indian tribe to purchase, directly or through the Service, managed care coverage for all members of the tribe from—

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

[(2) a State licensed managed care plan.

[(b) Not later than the date which is 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report containing—

[(1) a detailed description of the study conducted pursuant to this section; and

[(2) a discussion of the findings and conclusions of such study.]

§ 211. Indian Youth Program

(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Service, is authorized to establish and administer a program to provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and Urban Indian preadolescent and adolescent youths.

(b) USE OF FUNDS.—

(1) ALLOWABLE USES.—Funds made available under this section may be used to—

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

(B) develop and provide community training and education.

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

(c) DUTIES OF THE SECRETARY.—The Secretary shall—

(1) disseminate to Indian Tribes, Tribal Organizations, and Urban Indian Organizations information regarding models for the delivery of comprehensive health care services to Indian and Urban Indian adolescents;

(2) encourage the implementation of such models; and

(3) at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance in the implementation of such models.

(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

[§ 1621j. California contract health services demonstration program

[(a) ESTABLISHMENT

[The Secretary shall establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.

[(b) AGREEMENT WITH CALIFORNIA RURAL INDIAN HEALTH BOARD

[(1) In establishing such program, the Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred, during the period of the demonstration program, in providing medical treatment under contract to California Indians described in section 1679(b) of this title throughout the California contract health services delivery

area described in section 1680 of this title with respect to high-cost contract care cases.

[(2) Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the Board during such fiscal year.

[(3) No payment may be made for treatment provided under the demonstration program to the extent payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 1621a of this title or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

[(c) ADVISORY BOARD

[There is hereby established an advisory board which shall advise the California Rural Indian Health Board in carrying out the demonstration pursuant to this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under such demonstration, at least one half of whom are not affiliated with the California Rural Indian Health Board.

[(d) COMMENCEMENT AND TERMINATION DATES

[The demonstration program described in this section shall begin on January 1, 1993, and shall terminate on September 30, 1997.

[(e) REPORT

[Not later than July 1, 1998, the California Rural Indian Health Board shall submit to the Secretary a report on the demonstration program carried out under this section, including a statement of its findings regarding the impact of using a contract care intermediary on—

[(1) access to needed health services;

[(2) waiting periods for receiving such services; and

[(3) the efficient management of high-cost contract care cases.

[(f) "HIGH-COST CONTRACT CARE CASES" DEFINED

[For the purposes of this section, the term "high-cost contract care cases" means those cases in which the cost of the medical treatment provided to an individual—

[(1) would otherwise be eligible for reimbursement from the Catastrophic Health Emergency Fund established under section 1621a of this title, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 1621a(b)(2) of this title; and

[(2) exceeds $1,000.

[(g) AUTHORIZATION OF APPROPRIATIONS

[There are authorized to be appropriated for each of the fiscal years 1996 through 2000 such sums as may be necessary to carry out the purposes of this section.]

§ 212. Prevention, Control, and Elimination of Communicable and Infectious Diseases

(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, and after consultation with Indian Tribes, Tribal Organizations, Urban Indian Organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian

Tribes, Tribal Organizations, and Urban Indian Organizations for the following:

(1) Projects for the prevention, control, and elimination of communicable and infectious diseases including, but not limited to, tuberculosis, hepatitis, human immunodeficiency virus, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and Helicobacter Pylori Infections.

(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

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

(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

(1) may, at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance; and

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

[§ 1621k. Coverage of screening mammography

[The Secretary, through the Service, shall provide for screening mammography (as defined in section 1861(jj) of the Social Security Act [42 U.S.C.A. §1395x9JJ0]) for Indian and urban Indian women 35 years of age or older at a frequency, determined by the Secretary (in consultation with the Director of the National Cancer Institute), appropriate to such women, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act [42 U.S.C.A. §1395j et. seq.]. **]**

§ 213. Authority for Provision of Other Services

(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act, which shall include, but not be limited to—

(1) hospice care;

(2) assisted living;

(3) long-term health care;
(4) home- and community-based services;
(5) public health functions; and
(6) Traditional Health Care Practices.

(b) SERVICES TO OTHERWISE INELIGIBLE PERSONS.—At the discretion of the Service, Indian Tribes, or Tribal Organizations, services provided for hospice care, home health care, home- and community-based care, assisted living, and long-term care may be provided (subject to reimbursement of reasonable charges) to persons otherwise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to an Indian Tribe or Tribal Organization.

(c) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

(1) 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) Respite care.
(F) Training for family members.
(G) Adult day care.
(H) Such other home- and community-based services as the Secretary, an Indian Tribe, or Tribal Organization may approve.

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

(3) The term 'public health functions' means the provision of public health-related programs, functions, and services including, but not limited to, assessment, assurance, and policy development which Indian Tribes and Tribal Organizations are authorized and encouraged, in those circumstances where it meets their needs, to do by forming collaborative relationships with all levels of local, State, and Federal Government.

[§ 1621l. Patient travel costs

[(a) The Secretary, acting through the Service, shall provide funds for the following patient travel costs associated with receiving health care services provided (either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act [25 U.S.C.A. §450f et. seq.]) under this chapter—

[(1) emergency air transportation; and

[(2) nonemergency air transportation where ground transportation is infeasible.

[(b) There are authorized to be appropriated to carry out this section $15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.**]**

§ 214. Indian Women's Health Care

The Secretary, acting through the Service and Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall 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.

[§1621m. Epidemiology centers

[(a)(1) The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in paragraph (3).

[(2) To assist such centers in carrying out such functions, the Secretary shall perform the following:

[(A) In consultation with the Centers for Disease Control and Indian tribes, develop sets of data (which to the extent practicable, shall be consistent with the uniform data sets used by the States with respect to the year 2000 health objectives) for uniformly defining health status for purposes of the objectives specified in section 1602(b) of this title. Such sets shall consist of one or more categories of information. The Secretary shall develop formats for the uniform collecting and reporting of information on such categories.

[(B) Establish and maintain a system for monitoring the progress made toward meeting each of the health status objectives described in section 1602(b) of this title.

[(3) In consultation with Indian tribes and urban Indian communities, each area epidemiology center established under this subsection shall, with respect to such area—

[(A) collect data relating to, and monitor progress made toward meeting, each of the health status objectives described in section 1602(b) of this title using the data sets and monitoring system developed by the Secretary pursuant to paragraph (2);

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

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

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

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

[(F) work cooperatively with tribal providers of health and social services in order to avoid duplication of existing services; and

[(G) provide technical assistance to Indian tribes and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community.

[(4) Epidemiology centers established under this subsection shall be subject to the provisions of the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

[(5) The director of the Centers for Disease Control shall provide technical assistance to the centers in carrying out the requirements of this subsection.

[(6) The Service shall assign one epidemiologist from each of its area offices to each area epidemiology center to provide such center with technical assistance necessary to carry out this subsection.

[(b)(1) The Secretary may make grants to Indian tribes, tribal organizations, and eligible intertribal consortia or Indian organization to conduct epidemiological studies of Indian communities.

[(2) An intertribal consortia or Indian organization is eligible to receive a grant under this subsection if—

[(A) it is incorporated for the primary purpose of improving Indian health; and

[(B) it is representative of the tribes or urban Indian communities in which it is located.

[(3) An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

[(4) Applicants for grants under this subsection shall—

[(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

[(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

[(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

[(5) A grant awarded under paragraph (1) may be used to—

[(A) carry out the functions described in subsection (a)(3) of this section;

[(B) provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff, on health care and health services management issues; and

[(C) provide, in collaboration with tribes and urban Indian communities, the Service with information regarding ways to improve the health status of Indian people.

[(6) There are authorized to be appropriated to carry out the purposes of this subsection not more that $12,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 215. Environmental and Nuclear Health Hazards

(a) STUDIES AND MONITORING.—The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indian miners and to Indians on or near reservations and Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems, such as nuclear resource development, petroleum contamination, and contamination of water source and of the food chain. Such studies shall include—

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

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

(3) and evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including, but not limited to, uranium mining and milling, uranium mining tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation on or near reservations or Indian communities; and other development that could affect the health of Indians and their water supply and food chain;

(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

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

(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and, in consultation with Indian Tribes and Tribal Organizations, develop health care plans to address the health problems studied under subsection (a). The plans shall include—

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

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

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

(c) SUBMISSION OF REPORT AND PLAN TO CONGRESS.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

(d) INTERGOVERNMENTAL TASK FORCE.—

(1) ESTABLISHMENT; MEMBERS.—There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees):

(A) The Secretary of Energy.

(B) The Secretary of the Environmental Protection Agency.

(C) The Director of the Bureau of Mines.

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

(E) The Secretary of the Interior.

(F) The Secretary of Health and Human Services.

(G) The Director of the Indian Health Service.

(2) DUTIES.—The Task Force shall—

(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—In the case of any Indian who—

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

(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program from the employer for providing medical care for such illness or condition.

[§ 1621n. Comprehensive school health education programs

[(a) AWARD OF GRANTS

[The Secretary, acting through the Service and in consultation with the Secretary of the Interior, may award grants to Indian tribes to develop comprehensive school health education programs for children from preschool through grade 12 in schools located on Indian reservations.

[(b) USE OF GRANTS

[Grants awarded under this section may be used to—

[(1) develop health education curricula;

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

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

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

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

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

[(7) develop mental health wellness programs;

[(8) develop chronic disease prevention programs;

[(9) develop substance abuse prevention programs;

[(10) develop accident prevention and safety education programs;

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

[(12) develop community and environmental health education programs.

[(c) ASSISTANCE

[The Secretary shall provide technical assistance to Indian tribes in the development of health education plans, and the dissemination of health education materials and information on existing health programs and resources.

[(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS

[The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this section.

[(e) REPORT OF RECIPIENT

[Recipients of grants under this section shall submit to the Secretary an annual report on activities undertaken with funds provided under this section. Such reports shall include a statement of—

[(1) the number of preschools, elementary schools, and secondary schools served;

[(2) the number of students served;

[(3) any new curricula established with funds provided under this section;

[(4) the number of teachers trained in the health curricula; and

[(5) the involvement of parents, members of the community, and community health workers in programs established with funds provided under this section.

[(f) PROGRAM DEVELOPMENT

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

[(2) Such program shall include—

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

[(B) mental health wellness programs;

[(C) chronic disease prevention programs;

[(D) substance abuse prevention programs;

[(E) accident prevention and safety education programs; and

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

[(3) The Secretary of the Interior shall—

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

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

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

[(g) AUTHORIZATION OF APPROPRIATIONS

[There are authorized to be appropriated to carry out this section $15,000,000 for the fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 216. Arizona as a Contract Health Service Delivery Area

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

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

§ 216A. North Dakota 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 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).

§ 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 on 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 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).

[§ 1621*o*. Indian youth grant program

[(a) GRANTS

[The Secretary, acting through the Service, is authorized to make grants to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian preadolescent and adolescent youths.

[(b) USE OF FUNDS

[(1) Funds made available under this section may be used to—

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

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

[(2) Funds made available under this section may not be used to provide services described in section 1621h(m) of this title.

[(c) MODELS FOR DELIVERY OF COMPREHENSIVE HEALTH CARE SERVICES

[The Secretary shall—

[(1) disseminate to Indian tribes information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;]

[(2) encourage the implementation of such models; and]

[(3) at the request of an Indian tribe, provide technical assistance in the implementation of such models.

[(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS

[The Secretary shall establish criteria for the review and approval of applications under this section.

[(e) AUTHORIZATION OF APPROPRIATIONS

[There are authorized to be appropriated to carry out this section $5,000,000 for fiscal yar 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

§ 217. California Contract Health Services Program

(a) FUNDING AUTHORIZED.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the 'CRIHB') as a contract care intermediary to improve the accessibility of health services to California Indians.

(b) REIMBURSEMENT CONTRACT.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal

year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

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

(e) ADVISORY BOARD.—There is hereby established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least one half of whom are not affiliated with the CRIHB.

§ 218. California as a Contract Health Service Delivery Area

The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

§ 219. Contract Health Services for the Trenton Service Area

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

(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§ 1621p. American Indians Into Psychology Program

[(a) GRANTS

[The Secretary may provide grants to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field.

[(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM

[The Secretary shall provide one of the grants authorized under subsection (a) of this section to develop and maintain a program at the University of North Dakota to be known as the "Quentin N. Burdick American Indians Into Psychology Program". Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 1616g(b) of this title, the Quentin N. Burdick American Indi-

ans Indians Into Nursing Program authorized under section 1616e(e) of this title, and existing university research and communications networks.

[(c) ISSUANCE OF REGULATIONS

[(1) The Secretary shall issue regulations for the competitive awarding of the grants provided under this section.

[(2) Applicants for grants under this section shall agree to provide a program which, at a minimum—

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

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

[(C) provides summer enrichment programs to expose Indian students to the varied fields of psychology through research, clinical, and experiential activities;

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

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

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

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

[(d) ACTIVE DUTY SERVICE OBLIGATION

[The active duty service obligation prescribed under section 254m of Title 42 shall be met by each graduate student who receives a stipend described in subsection (c)(2)(D) of this section that is funded by a grant provided under this section. Such obligation shall be met by service—

[(1) in the Indian Health Service;

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

[(3) in a program assisted under subchapter IV of this chapter; or

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

[§ 1621q. Prevention, control, and elimination of tuberculosis

[(a) GRANTS

[The Secretary, acting through the Service after consultation with the Centers for Disease Control, may make grants to Indian tribes and tribal organizations for—

[(1) projects for the prevention, control, and elimination of tuberculosis;

[(2) public information and education programs for the prevention, control, and elimination of tuberculosis; and

[(3) education, training, and clinical skills improvement activities in the prevention, control, and elimination of tuberculosis for health professionals, including allied health professionals.

[(b) APPLICATION FOR GRANT

[The Secretary may make a grant under subsection (a) of this section only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains the assurances required by subsection (c) of this section and such other agreements, assurances, and information as the Secretary may require.

[(c) ELIGIBILITY FOR GRANT

[To be eligible for a grant under subsection (a) of this section, an applicant must provide assurances satisfactory to the Secretary that—

[(1) the applicant will coordinate its activities for the prevention, control, and elimination of tuberculosis with activities of the Centers for Disease Control, and State and local health agencies; and

[(2) the applicant will submit to the Secretary an annual report on its activities for the prevention, control, and elimination of tuberculosis.

[(d) DUTIES OF SECRETARY

[In carrying out this section, the Secretary—

[(1) shall establish criteria for the review and approval of applications for grants under subsection (a) of this section, including requirement of public health qualifications of applicants;

[(2) shall, subject to available appropriations, make at least one grant under subsection (a) of this section within each area office;

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

[(4) shall prepare and submit a report to the Committee on Energy and Commerce and the Committee on Natural Resources of the House and the Committee on Indian Affairs of the Senate not later than February 1, 1994, and biennially thereafter, on the use of funds under this section and on the progress made toward the prevention, control, and elimination of tuberculosis among Indian tribes and tribal organizations.

[(e) REDUCTION OF AMOUNT OF GRANT

[The Secretary may, at the request of a recipient of a grant under subsection (a) of this section, reduce the amount of such grant by—

[(1) the fair market value of any supplies or equipment furnished the grant recipient; and

[(2) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the grant recipient and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such grant recipient and for the purpose of carrying out

a program with respect to which the grant under subsection (a) of this section is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, and such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.

[§ 1621r. Contract health services payment study

[(a) DUTY OF SECRETARY

[The Secretary, acting through the Service and in consultation with representatives of Indian tribes and tribal organizations operating contract health care programs under the Indian Self-Determination Act (25 U.S.C. 450f et seq.) or under self-governance compacts, Service personnel, private contract health services providers, the Indian Health Service Fiscal Intermediary, and other appropriate experts, shall conduct a study—

[(1) to assess and identify administrative barriers that hinder the timely payment for services delivered by private contract health services providers to individual Indians by the Service and the Indian Health Service Fiscal Intermediary;

[(2) to assess and identify the impact of such delayed payments upon the personal credit histories of individual Indians who have been treated by such providers; and

[(3) to determine the most efficient and effective means of improving the Service's contract health services payment system and ensuring the development of appropriate consumer protection policies to protect individual Indians who receive authorized services from private contract health services providers from billing and collection practices, including the development of materials and programs explaining patients' rights and responsibilities.

[(b) FUNCTIONS OF STUDY

[The study required by subsection (a) of this section shall—

[(1) assess the impact of the existing contract health services regulations and policies upon the ability of the Service and the Indian Health Service Fiscal Intermediary to process, on a timely and efficient basis, the payment of bills submitted by private contract health services providers;

[(2) assess the financial and any other burdens imposed upon individual Indians and private contract health services providers by delayed payments;

[(3) survey the policies and practices of collection agencies used by contract health services providers to collect payments for services rendered to individual Indians;

[(4) identify appropriate changes in Federal policies, administrative procedures, and regulations, to eliminate the problems experienced by private contract health services providers and individual Indians as a result of delayed payments; and

[(5) compare the Service's payment processing requirements with private insurance claims processing requirement to evaluate the systemic differences or similarities employed by the Service and private insurers.

[(c) REPORT TO CONGRESS

[Not later than 12 months after October 29, 1992, the Secretary shall transmit to the Congress a report that includes—

[(1) a detailed description of the study conducted pursuant to this section; and

[(2) a discussion of the findings and conclusions of such study.

[§ 1621s. Prompt action on payment of claims

[(a) TIME OF RESPONSE

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

[(b) FAILURE TO TIMELY RESPOND

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

[(c) TIME OF PAYMENT

[The Service shall pay a completed contract care service claim within 30 days after completion of the claim.

[§ 1621t. Demonstration of electronic claims processing

[(a) Not later than June 15, 1993, the Secretary shall develop and implement, directly or by contract, 2 projects to demonstrate in a pilot setting the use of claims processing technology to improve the accuracy and timeliness of the billing for, and payment of, contract health services.

[(b) The Secretary shall conduct one of the projects authorized in subsection (a) of this section in the Service area served by the area office located in Phoenix, Arizona.

[§ 1621u. Liability for payment

[(a) A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

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

[§ 1621v. Office of Indian Women's Health Care

[There is established within the Service an Office of Indian Women's Health Care to oversee efforts of the Service to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.]

§ 220. Programs Operated by Indian Tribes and Tribal Organizations

The Service shall provide funds for health care programs and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

§ 221. Licensing or Certification

Health care professionals employed by a Tribal Health Program shall, if licensed or certified in any State, be exempt from the licensing or certification requirements of the State in which the Tribal Health Program performs the services described in its Funding Agreement.

§ 222. Notification of Provision of Emergency Contract Health Services

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

§ 223. Prompt Action on Payment of Claims

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

(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

(c) DEADLINE FOR PAYMENT OF VALID CLAIM—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

§ 224. Liability for Payment

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

(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

(c) NO RECOURSE.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 233(b), the provider shall have no further recourse against the patient who received the services.

§ 1621w. Authorization of appropriations

[Except as provided in sections 1621h(m), 1621j, 1621l, 1621m(b)(5), 1621n, and 1621o of this title, t**]** *T*here are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* **[**2000**]** to carry out this *title* **[**subchapter**]**.

[§ 1621x. Limitation on use of funds

[Amounts appropriated to carry out this subchapter may not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997 [42 U.S.C.A. § 14401 et seq.].

[§ 1622. Transferred]

TITLE [SUBCHAPTER] III—[HEALTH] FACILITIES

§ 1631. Consultation*: Construction and Renovation of Facilities;* [closure of facilities; r]*R*eports

(a) *PREREQUISITES FOR EXPENDITURE OF FUNDS.*—[CONSULTATION; STANDARDS FOR ACCREDITATION]

Prior to the expenditure of, or the making of any *binding* [firm] commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to *the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act')* [section 13 of this title, popularly known as the Snyder Act], the Secretary, acting through the Service, shall—

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

(2) ensure, whenever practicable *and applicable,* that such facility meets the *construction* standards of *any accrediting body recognized by the Secretary for the purposes of the medicare, medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act* [the Joint Commission on Accreditation of Health Care Organizations] by not later than 1 year after the date on which the construction or renovation of such facility is completed.

(b) CLOSURES.—[; REPORT ON PROPOSED CLOSURE]

(1) *EVALUATION REQUIRED.*—Notwithstanding any *other* provision of law, *no facility operated by the Service* [other than this subsection, no Service hospital or outpatient health care facility of the Service, or any portion of such a hospital or facility,] may be closed if the Secretary has not submitted to [the] Congress at least 1 year prior to the date *of the proposed closure* [such hospital or facility (or portion thereof) is proposed to be closed] an evaluation of the impact of *the* [such] proposed closure which specifies, in addition to other considerations—

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

(B) the cost-effectiveness of such closure;

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

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

(E) the views of the Indian [t]*T*ribes served by such [hospital or] facility concerning such closure;

(F) the level of *use of such* [utilization of such hospital or] facility by all eligible Indians; and

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

(2) *EXCEPTION FOR CERTAIN TEMPORARY CLOSURES*.—Paragraph (1) shall not apply to any temporary closure of a facility or [of] any portion of a facility if such closure is necessary for medical, environmental, or *construction* safety reasons.

(c) *HEALTH CARE FACILITY PRIORITY SYSTEM*.—[ANNUAL REPORT on HEALTH FACILITY PRIORITY SYSTEM]

(1) IN GENERAL.—

(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a health care facility priority system, which shall—

(i) be developed with Indian Tribes and Tribal Organizations through negotiated rulemaking under section 802;

(ii) give Indian Tribes' needs the highest priority; and

(iii) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E).

(B) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of the Indian Health Care Improvement Act Amendments of 2004 shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as 1 of the 10 top-priority inpatient projects, 1 of the 10 top-priority outpatient projects, 1 of the 10 top-priority staff quarters developments, or 1 of the 10 top-priority Youth Regional Treatment Centers in the fiscal year 2005 Indian Health Service budget justification, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of the enactment of such Act.

(2)[(1)] *REPORT; CONTENTS*.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to [the] Congress under section *801* [1671 of this title], a report which sets forth *the following*:[—]

(A) *A description of* the [current] health care facility priority system of the Service, *established under paragraph (1).*

(B) *Health care facilities lists, including but not limited to*—[the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters),]

(i) the 10 top-priority inpatient health care facilities;

(ii) the 10 top-priority outpatient health care facilities;

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

(iv) the 10 top-priority staff quarters developments associated with health care facilities; and

(v) the 10 top-priority patient hostels associated with health care facilities.

(C) [t]*T*he justification for such order of priority[,].

(D) [t]*T*he projected cost of such projects.[, and]

(E) [t]*T*he methodology adopted by the Service in establishing priorities under its health facility priority system.

(3)[(2)] *REQUIREMENTS FOR PREPARATION OF REPORTS.*—In preparing each report required under paragraph *(2)*[(1)] (other than the initial report), the Secretary shall *annually*—

(A) consult with *and obtain information on all health care facilities needs from* Indian [t]*T*ribes, *Tribal Organizations, and Urban Indian Organizations;* [and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],] and

(B) review the *total unmet* needs of all *Indian* [such t]*T*ribes, *Tribal Organizations, and Urban Indian Organizations* [and tribal organizations] for *health care* [inpatient and outpatient] facilities *(including hostels and staff quarters),* including [their] needs for renovation and expansion of existing facilities.

(4)[(3)] *CRITERIA FOR EVALUATING NEEDS.*—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any *Funding Agreement* [contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],] use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

(5)[(4)] *NEEDS OF FACILITIES UNDER ISDEAA AGREEMENTS.*—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities *operated under funding agreements in accordance with the* [which are the subject of a contract for health services entered into with the Service under the] Indian Self-Determination *and Education Assistance* Act *(25 U.S.C. 450 et seq.)* [[25 U.S.C.A. § 450f et seq.]] are fully and equitably integrated into [the development of] the health care facility priority system.

(d) REVIEW OF NEED FOR FACILITIES

(1) INITIAL REPORT.—In the year 2005, the Government Accountability Office shall prepare and finalize a report which sets forth the needs of the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, for the facilities listed under subsection (c)(2)(B), including the needs for renovation and expansion of existing facilities. The Government Accountability Office shall submit the report to the appropriate authorizing and appropriations committees of Congress and to the Secretary.

(2) Beginning in the year 2006, the Secretary shall update the report required under paragraph (1) every 5 years.

(3) The Comptroller General and the Secretary shall consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. The Secretary shall submit the reports required by paragraphs (1) and (2), to the President for inclusion in the report required to be transmitted to Congress under section 801.

(4) For purposes of this subsection, the reports shall, regarding the needs of facilities operated under any Funding Agreement, be based on the same criteria that the Secretary uses in

evaluating the needs of facilities operated directly by the Service.

(5) The planning, design, construction, and renovation needs of facilities operated under Funding Agreements shall be fully and equitably integrated into the development of the health facility priority system.

(6) Beginning in the year 2006 and each fiscal year thereafter, the Secretary shall provide an opportunity for nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration under the health care facility priority system.

(e) FUNDING CONDITION.—[(d) FUNDS APPROPRIATED SUBJECT TO SECTION 450F OF THIS TITLE]

All funds appropriated under the *Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'),* [section 13 of this title,] for the planning, design, construction, or renovation of health facilities for the benefit of *1 or more* [an] Indian [tribe or t]*T*ribes shall be subject to the provisions of [section 102 of] the Indian Self-Determination *and Education Assistance Act (25 U.S.C. 450 et seq.)* [[25 U.S.C.A. § 450f]].

(f) DEVELOPMENT OF INNOVATIVE APPROACHES.— The Secretary shall consult and cooperate with Indian Tribes, Tribal Organizations, and Urban Indian Organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

§ 1632. *Sanitation* [Safe water and sanitary waster disposal f]*F*acilities

(a) [CONGRESSIONAL F]*F*INDINGS.—

[The] Congress [hereby] finds *the following:* [and declares that—]

(1) [t]*T*he provision of *sanitation facilities* [safe water supply systems and sanitary sewage and solid waste disposal systems] is primarily a health consideration and function[;].

(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of *sanitation facilities.* [such systems;]

(3) [t]*T*he long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing *sanitation facilities* [such systems] and other preventive health measures[;].

(4) [m]*M*any Indian homes and *Indian* communities still lack *sanitation facilities.* [safe water supply systems and sanitary sewage and solid waste disposal systems; and]

(5) [i]*I*t is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with *sanitation facilities.* [safe and adequate water supply systems and sanitary sewage waste disposal systems as soon as possible.]

(b) *FACILITIES AND SERVICES.*—[AUTHORITY; ASSISTANCE; TRANSFER OF funds]

[(1)] In furtherance of the findings [and declarations] made in subsection (a) [of this section], Congress reaffirms the primary responsibility and authority of the Service to provide the

necessary sanitation facilities and services as provided in section *7 of the Act of August 5, 1954 (42 U.S.A. 2004a)* [2004a of Title 42]. *Under such authority,* [(2) T]*t*he Secretary, acting through the Service, is authorized to provide *the following:* [under section 2004a of Title 42.]

(1) [(A) f]*F*inancial and technical assistance to Indian [t]*T*ribes, *Tribal Organizations,* and *Indian* communities in the establishment, training, and equipping of utility organizations to operate and maintain [Indian] sanitation facilities[;], *including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.*

(2) [(B) o]*O*ngoing technical assistance and training to *Indian Tribes, Tribal Organizations, and Indian communities* in the management of utility organizations which operate and maintain sanitation facilities.[; and]

(3) [(C)] *Priority funding for* operation and maintenance assistance for, and emergency repairs to, [tribal] sanitation facilities *operated by an Indian Tribe, Tribal Organization or Indian community* when necessary to avoid *an imminent* [a] health hazard or to protect the [Federal] investment in the *health benefits gained through the provision of* sanitation facilities.

(c) FUNDING.—[(3)] Notwithstanding any other provision of law—

(1)[(A)] the Secretary of Housing and Urban *Development* [Affairs] is authorized to transfer funds appropriated under the *Native American* Housing *Assistance* and *Self-Determination* [Community Development] Act of *1996* [1974 (42 U.S.C. 5301 et seq.)] to the Secretary of Health and Human Services*;*[, and]

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

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

(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services and place these funds into Funding Agreements;

(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to fund up to 100 percent of the amount of an Indian Tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of sec-

tion 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

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

(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act; and

(9) the Secretary of Health and Human Services shall, by regulation developed through rulemaking under section 802, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act.

[(c) 10-YEAR PLAN

[Beginning in fiscal year 1990, the Secretary, acting through the Service, shall develop and begin implementation of a 10–year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.]

(d) *CERTAIN CAPABILITIES NOT PREREQUISITE.*—[TRIBAL CAPABILITY]

The financial and technical capability of an Indian [t]*T*ribe, *Tribal Organization,* or *Indian* community to safely operate, *manage,* and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

(e) *FINANCIAL* [AMOUNT OF A]*A*SSISTANCE.—

[(1)] The Secretary is authorized to provide financial assistance to Indian [t]*T*ribes, *Tribal Organizations* and *Indian* communities *for operation, management, and maintenance of their sanitation facilities.* [in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (c) of this section.]

[(2) For the purposes of paragraph (1), the term "Federal share" means 80 percent of the costs described in paragraph (1).

[(3) With respect to Indian tribes with fewer than 1,000 enrolled members, the non-Federal portion of the costs of operating, managing, and maintaining such facilities may be provided, in part, through cash donations or in kind property, fairly evaluated.]

(f) OPERATION, MANAGEMENT, AND MAINTENANCE OF FACILITIES.—The Indian Tribe, Tribal Organization, or Indian community has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities. If a sanitation facility serving a community that is operated by an Indian Tribe, Tribal Organization, or Indian community is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a

short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

(g) ISDEAA PROGRAM FUNDED ON EQUAL BASIS.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

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

(2) any funds appropriated for the purpose of providing sanitation facilities.

[(f) ELIGIBILITY OF PROGRAMS ADMINISTERED BY INDIAN TRIBES

[Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] shall be eligible for—

[(1) any funds appropriated pursuant to this section, and

[(2) any funds appropriated for the purpose of providing water supply or sewage disposal services,

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

(h) REPORT.—[(G) ANNUAL REPORT; SANITATION DEFICIENCY LEVELS]

(1) *REQUIRED; CONTENTS.*—The Secretary, *in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103))* shall submit to the President, for inclusion in each report required to be transmitted to [the] Congress under section *801*[1671 of this title], a report which sets forth—

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

(B) the methodology for determining sanitation deficiencies *and needs*;

(C) the level of *initial and final* sanitation deficiency for each *type of* sanitation facility [facilities] *for each type of* project of each Indian [t]*Tribe or Indian* community;

(D) the amount *and most effective use* of funds, *derived from whatever source,* necessary to *accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act, and to reduce the identified sanitation deficiency levels of* [raise] all Indian [t]*T*ribes and *Indian* communities to [a] level I sanitation deficiency *as defined in paragraph (4)(A);* and

(E) *a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.* [the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.]

(2) CRITERIA.—The criteria on which the deficiencies and needs will be evaluated shall be developed through negotiated rulemaking pursuant to section 802.

[(2) In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organization (including those tribes or tribal organizations operating health care programs or facili-

ties under any contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]) to determine the sanitation needs of each tribe.]

(3) *UNIFORM METHODOLOGY.*—The methodology used by the Secretary in determining, *preparing cost estimates for, and reporting* sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian [t]*T*ribes and *Indian* communities.

(4) *SANITATION DEFICIENCY LEVELS.*—For purposes of this subsection, the sanitation deficiency levels for an *individual,* Indian [t]*T*ribe or *Indian community sanitation facility to serve Indian homes* are *determined* as follows:

(A) *A* level I *deficiency exists if a sanitation facility serving* [is] an *individual,* Indian [t]*T*ribe or *Indian* community [with a sanitation system]—

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

(ii) [in which the] deficiencies relate to routine replacement, repair, or maintenance needs[;].

(B) *A* level II *deficiency exists if a sanitation facility serving an individual,* [is an] Indian [t]*T*ribe, or *Indian community substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to* [with a sanitation system]—

(i) *small or minor capital improvements needed to bring the facility back into compliance;* [which complies with all applicable water supply and pollution control laws, and]

(ii) [in which the deficiencies relate to] capital improvements that are necessary to *enlarge or* improve the facilities in order to meet the *current* needs [of such tribe or community] for domestic sanitation facilities; *or*

(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

(C) *A* level III *deficiency exists if a sanitation facility serving an individual,* [is an] Indian [t]*T*ribe or *Indian* community *meets one or more of the following conditions* [with a sanitation system which]—

(i) *water or sewer service in the home is provided by a haul system with holding tanks and interior plumbing;* [has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or]

(ii) *major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies; or* [has no solid waste disposal facility;]

(iii) there is no access to or no approved or permitted solid waste facility available.

(D) *A* level *IV deficiency exists if*—[(IV) is an Indian tribe or community with a sanitary system which lacks ei-

ther a safe water supply system or a sewage disposal system: and]

(i) a sanitation facility of an individual, Indian Tribe, Tribal Organization, or Indian community has no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure; or

(ii) where only a washeteria or central facility exists in the community.

(E) *A* level *V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.* [(V) is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.]

(j) DEFINITIONS.—For purposes of this section, the following terms apply:

(1) INDIAN COMMUNITY.—the term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

(2) SANITATION FACILITIES.—The terms 'sanitation facility' and 'sanitation facilities' mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).

[(5) For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.]

§ 1633. Preference to Indians and Indian firms

(a) *BUY INDIAN ACT.*—[DISCRETIONARY AUTHORITY; COVERED ACTIVITIES.]

The Secretary, acting through the Service, may *use* [utilize] the negotiating authority of section *23* [47] of *the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the 'Buy Indian Act')* [this title], to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian [t]*T*ribes in the State of New York (hereinafter referred to as an "Indian firm") in the construction and renovation of Service facilities pursuant to section *301* [1631 of this title] and in the construction of *sanitation* [safe water and sanitary waste disposal] facilities pursuant to section *302* [1632 of this title]. Such preference may be accorded by the Secretary unless *the Secretary* [he] finds, pursuant to [rules and] regulations [promulgated] *adopted pursuant to section 802* [by him], that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at *such a* [his] finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

(1) ownership and control by Indians[,]*;*

(2) equipment[,]*;*

(3) bookkeeping and accounting procedures[,]*;*

(4) substantive knowledge of the project or function to be contracted for**[**,**]***;*

(5) adequately trained personnel**[**,**]***;* or

(6) other necessary components of contract performance.

(b) *LABOR STANDARDS*.—**[**PAY RATES**]**

(1) IN GENERAL.—For the purpose of implementing the provisions of this *title* **[**subchapter**]***, contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with subchapter IV of chapter 31 of title 40, United States Code (commonly known as the 'Davis-Bacon Act'), unless such construction or renovation*—**[**the secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this subchapter are not less than the prevailing local wage rates for similar work as determined in accordance with sections 3141 to 3144, 3146, 3147 of Title 40.**]**

(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract, compact or funding agreement authorized by the Indian Self-Determination and Education Assistance Act, or other statutory authority; and

(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal Organizations to be served by the construction or renovation.

(2) EXCEPTION.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

§ 1634. Expenditure of **[**n**]***Non***[**-S**]***service* **[**f**]***Funds* for **[**r**]***Renovation*

(a) *IN GENERAL*.—**[**AUTHORITY OF SECRETARY**]**

[(1)**]** Notwithstanding any other provision of law, *if the requirements of subsection (c) are met,* the Secretary, *acting through the Service,* is authorized to accept any major *expansion,* renovation or modernization by any Indian **[**t**]***Tribe or Tribal Organization* of any Service facility, or of any other Indian health facility operated pursuant to a *Funding Agreement,* **[**contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]**]** including—

*(1)***[**(A)**]** any plans or designs for such expansion, renovation or modernization; and

*(2)***[**(B)**]** any expansion, renovation or modernization for which funds appropriated under any Federal law were lawfully expended. **[**, but only if the requirements of subsection (b) of this section are met.**]**

(b) PRIORITY LIST.—

*(1)***[**(2)**]** *IN GENERAL*.—The Secretary shall maintain a separate priority list to address the needs *for increased operating expenses,* **[**of such facilities for**]** personnel, or equipment *for such facilities. The methodology for establishing priorities shall*

be developed through negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.

(2)[(3)] *REPORT.*—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to [the] Congress under section *801* [1671 of this section], the priority list maintained pursuant to paragraph *(1)*[(2)].

(c)[(b)] REQUIREMENTS

The requirements of this subsection are met with respect to any *expansion,* renovation or modernization if—

(1) the *Indian T*[t]ribe or [t]*T*ribal [o]*O*rganization—

(A) provides notice to the Secretary of its intent to *expand,* renovate or modernize; and

(B) applies to the Secretary to be place on a separate priority list to address the needs of such new facilities for *increased operating expenses,* personnel or equipment; and

(2) the *expansion,* renovation or modernization—

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

(B) is administered by the *Indian T*[t]ribe *or Tribal Organization* in accordance with *any applicable* [the rules and] regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—In addition to the requirements in subsection (c), for any expansions, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information developed through negotiated rulemaking under section 802, including additional staffing, equipment, and other costs associated with the expansion.

(e) CLOSURE OR CONVERSION OF FACILITIES.—[(c) RECOVERY FOR NON-USE AS SERVICE FACILITY]

If any Service facility which has been *expanded,* renovated or modernized by an Indian [t]*T*ribe *or Tribal Organization* under this section ceases to be used as a Service facility during the 20-year period beginning on the date such *expansion,* renovation or modernization is completed, such Indian [t]*T*ribe *or Tribal Organization* shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such *expansion,* renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such *expansion,* renovation or modernization) bore to the value of such facility at the time of the completion of such *expansion,* renovation or modernization.

[§ 1635. Repealed. Pub.L. 100–713, Title III, § 303(b), Nov. 23, 1988, 102 Stat. 4817]

§ 1636. *Funding* [Grant program] for the [c]*C*onstruction, [e]*E*xpansion, and [m]*M*odernization of [s]*S*mall [a]*A*mbulatory [c]*C*are [f]*F*acilities

(a) *FUNDING.*—[AUTHORIZATION]

(1) IN GENERAL.—The Secretary, acting through the Service, *in consultation with Indian Tribes and Tribal Organizations,* shall make *funding available* [grants] to *Indian T*[t]ribes and

[t]*T*ribal [o]*O*rganizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons *pursuant to subsections (b)(2) and (c)(1)(C)* [as provided in subsection (c)(1)(C) of this section)]. *Funding* [A grant] made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term ["]*'*construction*'*["] includes the replacement of an existing facility.

(2) *FUNDING AGREEMENT REQUIRED.—Funding* [A grant] under paragraph (1) may only be *available* [made] to a *Tribal Health Program* [tribe or tribal organization] operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to a *Indian T*[t]ribe or [t]*T*ribal [o]*O*rganization) [pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.]].

(b) USE OF *FUNDS* [GRANT]

(1) *ALLOWABLE USES.—Funding* [A grant] provided under this section may be used [only] for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

(A) located apart from a hospital;

(B) not funded under section *301*[1631] or section *307*[1637 of this title]; and

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

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

(ii) *provide annually no fewer than 150 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(c)(2)* [serve no less than 500 eligible Indians annually]; and

(iii) provide ambulatory care in a [s]*S*ervice [a]*A*rea (specified in the *Funding Agreement* [contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]]) with a population of *no fewer than 1,500* [not less than 2,000] eligible Indians *and other users who are eligible for services in such facility in accordance with section 807(c)(2).*

(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the construction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project or

debt reduction that benefits the Service population identified above in subsection (b)(1)(C)(ii) and (iii).

(4) *APPLICABILITY OF REQUIREMENTS IN THE CASE OF ISOLATED FACILITIES.*—[(2)] The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to *an Indian Tribe* [a tribe] or [t]*T*ribal [o]*O*rganization applying for *funding* [a grant] under this section *for a health care facility* [whose tribal government offices are] located *or to be constructed* on an island *or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.*

(c) *FUNDING.*—[APPLICATION FOR GRANT]

(1) *APPLICATION.*—No *funding* [grant] may be made *available* under this section unless an application *or proposal* for such *funding has been* [a grant has been submitted to and] approved by the Secretary *in accordance with applicable regulations and has provided reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section*—[. An application for a grant under this section shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to a grant received under this section—]

(A) adequate financial support will be available for the provision of services at such facility;

(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

(2) *PRIORITY.*—In awarding *funding* [grants] under this section, the Secretary shall give priority to *Indian T*[t]ribes and [t]*T*ribal [o]*O*rganizations that demonstrate—

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

(B) insufficient capacity to deliver such services.

(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed during consultations pursuant to subsection (a)(1).

(d) *REVERSION OF FACILITIES.*—[TRANSFER OF INTEREST TO UNITED STATES UPON CESSATION OF FACILITY]

If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, *within 5 years* [at any time] after completion of the construction, expansion, or modernization carried out with such funds, to be *used* [utilized] for the purposes of providing *health* [ambulatory] care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States *unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.*

(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion

in any individual Indian Tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

§ 1637. Indian [h]*H*ealth [c]*C*are [d]*D*elivery [d]*D*emonstration [p]*P*roject

(a) HEALTH [c]*C*ARE [DELIVERY D]*D*EMONSTRATION [P]*P*ROJECTS.—

The Secretary, acting through the Service, *and in consultation with Indian Tribes and Tribal Organizations,* is authorized to enter into *construction project agreements and construction contracts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)* with[, or make grants to,] Indian [t]*T*ribes or [t]*T*ribal [o]*O*rganizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through [health] facilities, *including but not limited to hospice, traditional Indian health, and child care facilities* [to Indians].

(b) USE OF [f]*F*UNDS

The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

(1) waive any leasing prohibition;

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

(3) permit the use of *other available* [non-Service Federal funds and non-Federal] funds;

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

(5) provide for the reversion of donated real or personal property to the donor[.]*; and*

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

(c) *REGULATIONS*.—[CRITERIA]

[(1) Within 180 days after November 28, 1990, t]*T*he Secretary[, after consultation with Indian tribes and tribal organizations,] shall develop and *promulgate regulations not later than 1 year after the enactment of the Indian Health Care Improvement Act Amendments of 2004. If the Secretary has not promulgated regulations by that date, the Secretary shall develop and publish regulations, through rulemaking under 802,* [in the Federal Register criteria] for the review and approval of applications submitted under this section.

(d) CRITERIA.—The Secretary may *approve* [enter into a contract or award a grant under this section for] projects *that* [which] meet the following criteria:

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

(2)[(B)] A significant number of Indians, including those with low health status, will be served by the project.

[(C) The project has the potential to address the health needs of Indians in an innovative manner.]

(3)[(D)] The project has the potential to deliver services in an efficient and effective manner.

(4)[(E)] The project is economically viable.

(5)[(F)] The Indian [t]*T*ribe or [t]*T*ribal [o]*O*rganization has the administrative and financial capability to administer the project.

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

(e) PEER REVIEW PANELS.—[(2)] The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications [and to advise the Secretary regarding such applications] using the criteria developed pursuant to *subsection (d)* [paragraph (1)].

(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects [(3)(A) On or before September 30, 1995, the Secretary shall enter into contracts or award grants under this section for a demonstration project] in each of the following [s]*S*ervice [u]*U*nits *to the extent that such applications are timely filed and meet the criteria specified in subsection (d):* [which meets the criteria specified in paragraph (1) and for which a completed application has been received by the Secretary:]

(1)[(i)] Cass Lake, Minnesota.

(2)[(ii)] Clinton, Oklahoma.

(3)[(iii)] Harlem, Montana.

(4)[(iv)] Mescalero, New Mexico

(5)[(v)] Owyhee, Nevada.

(6)[(vi)] Parker, Arizona.

(7)[(vii)] Schurz, Nevada.

(8)[(viii)] Winnebago, Nebraska.

(9)[(ix)] Ft. Yuma, California.

[(B) The Secretary may also enter into contracts or award grants under this section taking into consideration applications received under this section from all service areas. The Secretary may not award a greater number of such contracts or grants in one service area than in any other service area until there is an equal number of such contracts or grants awarded with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria specified in paragraph (1).]

(g)[(d)] TECHNICAL [a]*A*SSISTANCE.—

The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

(h)[(e)] SERVICE TO [I]*I*NELIGIBLE [P]*P*ERSONS.—

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 [s]*S*ervice facilities to non-Service health care practitioners as provided in section *807*[1680c of this title] may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

(i)[(f)] EQUITABLE [T]*T*REATMENT.—

For purposes of subsection *(d)(1)*[(c)(1)(A) of this section], the Secretary shall, in evaluating facilities operated under any *Funding Agreement,* [contract entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.],] use the

same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

(j)[(g)] EQUITABLE [I]*I*NTEGRATION OF [F]*F*ACILITIES.—

The Secretary shall ensure that the planning, design, construction, [and] renovation, *and expansion* needs of Service and non-Service facilities which are the subject of a *Funding Agreement* [contract] for health services [entered into with the Service under the Indian Self-Determination Act [25 U.S.C.A. 450f et seq.],] are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

[(h) REPORT TO CONGRESS

[(1) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 1671 of this title for fiscal year 1997, an interim report on the findings and conclusions derived from the demonstration projects established under this section.

[(2) The Secretary shall submit to the President, for inclusion in the report which is required to be submitted to the Congress under section 1671 of this title for fiscal year 1999, a final report on the findings and conclusions derived from the demonstration projects established under this section, together with legislative recommendations.]

§ 1638. Land [t]*T*ransfer

Notwithstanding any other provision of law, [T]*t*he Bureau of Indian Affairs *and all other agencies and departments of the United States are* [is] authorized to transfer, at no cost, *land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.* [up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.]

§ 308. Leases, Contracts, and Other Agreements

The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organization which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination and Education Assistance Act and regulations thereunder. Notwithstanding any other provision of law, such leases, contracts, or other agreements shall be considered as operating leases for the purpose of scoring under the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901 et seq.).

§ 309. Study on Loans, Loan Guarantees, and Loan Repayment

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

(1) inpatient facilities;

(2) outpatient facilities;

(3) staff quarters;

(4) hostels; and

(5) specialized care facilities, such as behavioral health and elder care facilities.

(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;

(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

(6) whether acceptance by the Secretary of an assignment of the revenue of an Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate;

(7) whether, in the planning and design of health facilities under this section, users eligible under section 807(c) may be included in any projection of patient population;

(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

(c) REPORT.—Not later than September 30, 2006, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

(1) the manner of consultation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.

§ 310. Tribal Leasing

A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

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

(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to negotiate and enter into arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible under this section if, when it submits a letter of intent, it—

(1) has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project; or

(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project.

(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization only if—

(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

(2) the Indian Tribe or Tribal Organization meets the need criteria which shall be developed through the negotiated rulemaking process provided for under section 802.

(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe's or Tribal Organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10–year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

(f) DEFINITION.—For the purposes of this section, the term 'health facility' or 'health facilities' includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

§ 312. Location of Facilities

(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

(b) DEFINITION.—For purposes of this section, the term 'Indian lands' means—

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

(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation; and

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

§ 313. Maintenance and Improvement of Health Care Facilities

(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the negotiated rulemaking process provided for under section 802.

(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed

a maximum renovation cost threshold. The maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

§ 314. Tribal Management of Federally Owned Quarters

(a) RENTAL RATES.—

(1) ESTABLISHMENT.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a Funding Agreement shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objections:

(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.

(b) DIRECT COLLECTION OF RENT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the maintenance (including capital repairs and

replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.

[§ 1638a. Authorization of appropriations

[There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this subchapter.]

§ 1638b. Applicability of Buy American *Act R*[r]equirement

(a) *APPLICABILITY*.—[DUTY OF SECRETARY]

The Secretary shall ensure that the requirements of the Buy American Act [[41 U.S.C.A. § 10a et seq.]] apply to all procurements made with funds provided pursuant to [the authorization contained in] section *317*[1638a of this title]. *Indian Tribes and Tribal Organizations shall be exempt from these requirements.*

[(b) REPORT TO CONGRESS

[The Secretary shall submit to the Congress a report on the amount of procurements from foreign entities made in fiscal years 1993 and 1994 with funds provided pursuant to the authorization contained in section 1638a of this title. Such report shall separately indicate the dollar value of items procured with such funds for which the Buy American Act [41 U.S.C.A. § 10a et seq.] was waived pursuant to the Trade Agreement Act of 1979 [19 U.S.C.A. § 2501 et seq.] or any international agreement to which the United States is a party.]

(b) [(c)] *EFFECT OF VIOLATION*.—[FRAUDULENT USE OF MADE-IN-AMERICA LABEL]

If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a ["]'Made in America'["] inscription[,] or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to [the authorization contained in] section *317*[1638a of this title], pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(c) [(d)] *DEFINITIONS*.—["BUY AMERICAN ACT" DEFINED]

For purposes of this section, the term [“]'Buy American Act'[”] means title III of the Act entitled “An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes”, approved March 3, 1933 (41 U.S.C. 10a et seq.).

§ 316. Other Funding For Facilities

(a) AUTHORITY TO ACCEPT FUNDS.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to transfer such funds to Indian Tribes or Tribal Organizations through construction project agreements or construction contracts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

(c) TRANSFERRED FUNDS.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

(d) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation, developed by rulemaking under section 802, for the planning, design, and construction of health care facilities serving Indians under this Act.

§ 317. Authorization of Appropriations

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

[§1638c. Contracts for personal services in Indian Health Service facilities

[In fiscal year 1995 and thereafter—

[(a) IN GENERAL

[The Secretary may enter into personal services contracts with entities, either individuals or organizations, for the provision of services in facilities owned, operated or constructed under the jurisdiction of the Indian Health Service.

[(b) EXEMPTION FROM COMPETITIVE CONTRACTING REQUIREMENTS

[The Secretary may exempt such a contract from competitive contracting requirements upon adequate notice of contracting opportunities to individuals and organizations residing in the geographic vicinity of the health facility.

[(c) CONSIDERATION OF INDIVIDUALS AND ORGANIZATIONS

[Consideration of individuals and organizations shall be based solely on the qualifications established for the contract and the proposed contract price.

[(d) LIABILITY

[Individuals providing health care services pursuant to these contracts are covered by the Federal Tort Claims Act.

[§1638d. Credit to appropriations of money collected for meals at Indian Health Service facilities

[Money before, on, and after September 30, 1994, collected for meals served at Indian Health Service facilities will be credited to the appropriations from which the services were furnished and shall be credited to the appropriation when received.]

TITLE IV [SUBCHAPTER III–A]—ACCESS TO HEALTH SERVICES

§1641. Treatment of [p]*P*ayments [u]*U*nder *Social Security Act Health Care* [medicare] *P*[p]rograms

(a) *DISREGARD OF MEDICARE, MEDICAID, AND SCHIP PAYMENTS IN DETERMINING APPROPRIATIONS* [DETERMINATION OF APPROPRIATIONS]

Any payments received by *an Indian Health Program or by an Urban Indian Organization made under title XVIII, XIX, or XXI of the Social Security Act* [a hospital or skilled nursing facility of the Service (whether operated by the Service or by an Indian tribe or tribal organization pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A.§450f et seq.])] for services provided to Indians eligible for benefits under *such respective titles* [Title XVIII of the Social Security Act [42 U.S.C.A. §1395 et seq.]] shall not be considered in determining appropriations for *the provision of* health care and services to Indians.

(b) *NONPREFERENTIAL TREATMENT*.—[PREFERENCES]

Nothing in this *Act* [chapter] authorizes the Secretary to provide services to an Indian [beneficiary] with coverage under title XVIII, *XIX, or XXI* of the Social Security Act [[42 U.S.C.A. §1395 et seq.], as amended,] in preference to an Indian [beneficiary] without such coverage.

[§1642. Treatment of payments under medicaid program]

(c)[(a)] *USE OF FUNDS*.—[PAYMENTS TO SPECIAL FUND]

(1) SPECIAL FUND.—Notwithstanding any other provision of law, *but subject to paragraph (2)*, payments to which a[ny] facility of the Service [(including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under Title XIX of the Social Security Act [42 U.S.C.A. §1396 et seq.])] is entitled [under a State plan] by reason of *a provision of the Social Security Act* [section 1911 of such Act [42 U.S.C.A. §1396j]] shall be placed in a special fund to be held by the Secretary and *first* used [by him] (to such extent or in such amounts as are provided in appropriation Acts) [exclusively] for the purpose of making any improvements in the *programs* [facilities] of *the* [such] Service

which may be necessary to achieve *or maintain* compliance with the applicable conditions and requirements of [such] titles *XVIII, XIX, and XXI of the Social Security Act. Any amounts to be reimbursed that are in excess of the amounts necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with Indian Tribes being served by the Service Unit, be used for reducing the health resource deficiencies of the Indian Tribes*. In making payments from such fund, the Secretary shall ensure that each [s]*S*ervice [u]*U*nit of the Service receives *100* [at least 80] percent of the amount[s] to which the facilities of the Service, for which such [s]*S*ervice [u]*U*nit makes collections, are entitled by reason of *a provision* [section 1911] of the Social Security Act [[42 U.S.C.A. §1396j]].

(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply upon the election of a Tribal Health Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided during the period of such election.

(d) DIRECT BILLING.—

(1) IN GENERAL.—A Tribal Health Program may directly bill for, and receive payment for, health care items and services provided by such Indian Tribe or Tribal organization for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

(2) DIRECT REIMBURSEMENT.—

(A) USE OF FUNDS.—Each Tribal Health Program exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to section 401(c), but all amounts so reimbursed shall be used by the Tribal Health Program for the purpose of making any improvements in Tribal facilities or Tribal Health Programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and Tribal Health Programs, any health care-related purpose, or otherwise to achieve the objectives provided in section 3 of this Act.

(B) AUDITS.—The amounts paid to an Indian Tribe or Tribal Organization exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be subject to all auditing requirements applicable to programs administered by an Indian Health Program.

(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian Tribe or Tribal Organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an Urban Indian Organization receives funding from the Service under title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian Tribe

or Tribal Organization, or Urban Indian Organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under a title of the Social Security Act.

(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

[(b) DETERMINATION OF APPROPRIATIONS

[Any payments received by such facility for services provided to Indians eligible for benefits under title XIX of the Social Security Act [42 U.S.C.A. §1396 et seq.] shall not be considered in determining appropriations for the provision of health care and services to Indians.

[§1643. Amount and use of funds reimbursed through medicare and medicaid available to Indian Health Service

[The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 1671 of this title, an accounting on the amount and use of funds made available to the Service pursuant to this subchapter as a result of reimbursements through Titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§1395 et seq., 1396 et seq.], as amended.**]**

§1644. Grants to and *Funding Agreements* [contracts] with *the Service, Indian Tribes, T*[t]ribal [o]*Organizations, and Urban Indian Organizations*

(a) *INDIAN TRIBES AND TRIBAL ORGANIZATIONS*.—**[**ACCESS TO HEALTH SERVICES**]**

The Secretary, acting through the Service, shall make grants to or enter into *Funding Agreements* **[**contracts**]** with *Indian Tribes and T*[t]ribal *O*[o]rganizations to assist such *Tribes and Tribal O*[o]rganizations in establishing and administering programs on or near **[**Federal Indian**]** reservations and trust areas **[**and in or near Alaska Native villages**]** to assist individual Indians **[**to**]**—

(1) *to* enroll *for benefits* under *title XVIII, XIX, or* XXI **[**section 1818 of part A and sections 1836 and 1837 of part B of

Title XVIII] of the Social Security Act *and other health benefits programs* [[42 U.S.C.A. §§1395i–2, 1395o, 1395p]]; *and*

(2) *to* pay [monthly] premiums for coverage *for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Tribe or Tribes)*. [due to financial need of such individual; and

[(3) apply for medical assistance provided pursuant to Title XIX of the Social Security Act [42 U.S.C.A. §1396 et seq.].]

(b) [TERMS AND C]*C*ONDITIONS.—

The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any [contract or] grant or *Funding Agreement* which the Secretary makes with any *Indian Tribe or T*[t]ribal *O*[o]rganization pursuant to this section. Such conditions shall include [, by are not limited to,] requirements that the *Indian Tribe or Tribal O*[o]rganization successfully undertake [to]—

(1) *to* determine the population of Indians *eligible for the* [to be served that are or could be recipients of] benefits *described in subsection (a)* [under Titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§1395 et seq., 1396 et seq.]];

(2) *to educate* [assist individual] Indians *with respect to the benefits available under the respective programs* [in becoming familiar with and utilizing such benefits];

(3) *to* provide transportation *for* [to] such individual Indians to the appropriate offices for enrollment or applications for *such benefits* [medical assistance];

(4) *to* develop and implement[—]

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

[(B)] methods of improving the participation of Indians in receiving the benefits provided under titles XVIII, [and] XIX, *and XXI* of the Social Security Act [[42 U.S.C.A. §§1395 et seq. And 1396 et seq.]].

(c) *AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT PROGRAMS*.—[APPLICATION FOR MEDICAL ASSISTANCE]

(1) AGREEMENTS WITH SECRETARY TO IMPROVE RECEIPT AND PROCESSING OF APPLICATIONS.—

(A) *AUTHORIZATION*.—The Secretary, acting through the Service, may enter into an agreement with an Indian [t]*T*ribe, [t]*T*ribal [o]*O*rganization, or [u]*U*rban Indian [o]*O*rganization which provides for the receipt and processing of applications *by Indians* for [medical] assistance under titles XIX and XXI of the Social Security Act, [[42 U.S.C.A. §1396 et seq.]] and benefits under title XVIII of *such* [the Social Security] Act, *by an Indian Health Program or Urban Indian Organization*. [[42 U.S.C.A. §1395 et seq.] at a Service facility or a health care facility administered by such tribe or organization pursuant to a contract under the Indian Self-Determination Act [25 U.S.C.A §450f et seq.].]

(B) REIMBURSEMENT OF COSTS.—Such agreements may provide for reimbursement of costs of outreach, education

regarding eligibility and benefits, and translation when such services are provided. The reimbursement may, as appropriate, be added to the applicable rate per encounter or be provided as a separate fee-for-service payment to the Indian Tribe or Tribal Organization.

(C) PROCESSING CLARIFIED.—In this paragraph, the term 'processing' does not include a final determination of eligibility.

(2) AGREEMENTS WITH STATES FOR OUTREACH ON OR NEAR RESERVATION.—

(A) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under title XIX or XXI of the Social Security Act, as a condition of continuing approval of a State plan under such title, the State shall take steps as to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with Indian Tribes and Tribal Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are provided.

(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting arrangements entered into between States and Indian Tribes and Tribal Organizations for such Indian Tribes and Tribal Organizations to conduct administrative activities under such titles.

(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations.

(e) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to Urban Indian Organizations with respect to populations served by such organizations in the same manner they apply to grants and Funding Agreements with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

(2) REQUIREMENTS.—The Secretary shall include in the grants or Funding Agreements made or provided under paragraph (1) requirements that are—

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

(B) appropriate to Urban Indian Organizations and Urban Indians; and

(C) necessary to effect the purposes of this section.

[§ 1645. Direct billing of Medicare, Medicaid, and other third party payors

[(a) ESTABLISHMENT OF DIRECT BILLING PROGRAM

[(1) IN GENERAL

[The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Service under the Indian Self-Determina-

tion 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 title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (In this section referred to as the "medicare program"), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (In this section referred to as the "medicaid program"), or from any other third party payor.

[(2) APPLICATION OF 100 PERCENT FMAP

[The third sentence of section 1396d(b) of Title 42 shall apply for purposes of reimbursement under the medicaid program for health care services directly billed under the program established under this section.

[(b) DIRECT REIMBURSEMENT

[(1) USE OF FUNDS

[Each hospital or clinic participating in the program described in subsection (a) of this section shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 1642(a) and 1680c(b)(2)(A) of this title, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid programs. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—

[(A) solely for improving the health resources deficiency level of the Indian tribe; and

[(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

[(2) AUDITS

[The amounts paid to the hospitals and clinics participating in the program established under this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

[(3) SECRETARIAL OVERSIGHT

[The Secretary shall monitor the performance of hospitals and clinics participating in the program established under this section, and shall require such hospitals and clinics to submit reports on the program to the Secretary on an annual basis.

[(4) NO PAYMENTS FROM SPECIAL FUNDS

[Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C.A. § 1395qq(c)) or section 1642(a) of this title, no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or clinic participates in the program established under this section.

[(c) REQUIREMENTS FOR PARTICIPATION

[(1) APPLICATION

[Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—

[(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;

[(B) the facility is eligible to participate in the medicare or medicaid programs under section 1395qq or 1396j of Title 42;

[(C) the facility meets the requirements that apply to programs operated directly by the Service; and

[(D) the facility—

[(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or

[(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.

[(2) APPROVAL

[(A) IN GENERAL

[The Secretary shall review and approve a qualified application not later than 90 days after the date that application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.

[(B) Grandfather of demonstration program participants

[Any participant in the demonstration program authorized under this section as in effect on November 1, 2000, shall be deemed approved for participation in the program established under this section and shall not be required to submit an application in order to participate in the program.

[(C) DURATION

[An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved applicant or the deemed approved demonstration program meets the requirements of this section.

[(d) EXAMINATION AND IMPLEMENTATION OF CHANGES

[(1) IN GENERAL

[The Secretary, acting through the Service, and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement—

[(A) any administrative changes that may be necessary to facilitate direct bill and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under the Medicaid program; and

[(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on pa-

tients served under the program that is consistent with the medical records information system of the Service.

[(2) ACCOUNTING INFORMATION

[The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before November 1.2000. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

[(e) WITHDRAWAL FROM PROGRAM

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

§ 403. Reimbursement From Certain Third Parties of Costs of Health Services

(a) RIGHT OF RECOVERY.—Except as provided in subsection (f), the United States, and Indian Tribe, or Tribal Organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed (or, if charges are not billed, the operational, administrative, and other expenses incurred) by the Secretary, an Indian Tribe, or Tribal Organization in providing health services, through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

(1) such services had been provided by a nongovernmental provider; and

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

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

(1) workers' compensation laws; or

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

(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the injured person the recovery for that portion of the person's damage not covered hereunder.

(e) ENFORCEMENT.—

(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—

(A) intervening or joining in any civil action or proceeding brought—

(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or

(ii) by any representative or heirs of such individual, or

(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political subdivision or local governmental entity of a State, such an action against an official thereof.

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

(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

(g) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys' fees and costs of litigation.

(h) RIGHT OF ACTION AGAINST INSURERS, HMOS, EMPLOYEE BENEFIT PLANS, SELF-INSURANCE PLANS, AND OTHER HEALTH CARE PLANS OR PROGRAMS.—Where an insurance company, health maintenance organization, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program fails or refuses to pay the amount due under subsection (a) for services provided to an individual who is a beneficiary, participant, or insured of such company, organization, plan, or program, the United States, Indian Tribe, or Tribal Organization shall have a right to assert and pursue all the claims and remedies against such company, organization, plan, or program and against the fiduciaries of such company, organization, plan, or program that the individual could assert or pursue under the terms of the contract, program, or plan or applicable Federal, State, or Tribal law.

(i) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, manage care plan, or other health care plan or program

(under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act, or recognized under section 1175 of such Act.

(j) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to Urban Indian Organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with respect to populations served by such Indian Tribes and Tribal Organizations.

(k) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

(l) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.).

§ 404. Crediting of Reimbursements

(a) USE OF AMOUNTS.—

(1) RETENTION BY PROGRAM.—Except as provided in section 202(g) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an Urban Indian Organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

(A) Titles XVIII, XIX, and XXI of the Social Security Act.

(B) This Act, including section 807.

(C) Public Law 87–693.

(D) Any other provision of law.

(b) NO OFFSET OF AMOUNTS.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

§ 405. Purchasing Health Care Coverage

(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act, or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health benefits for Serv-

ice beneficiaries, Indian Tribes, Tribal Organizations, and Urban Indian Organizations may use such amounts to purchase health benefits coverage for such beneficiaries in any manner, including through—

(1) a tribally owned and operated health care plan;

(2) a State or locally authorized or licensed health care plan;

(3) a health insurance provider or managed care organization; or

(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

§ 406. Sharing Arrangements with Federal Agencies

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

(2) the quality of health care services provided to any Indian through the Service;

(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

§ 407. Payor of Last Resort

Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

§ 408. Nondiscrimination in Qualifications for Reimbursement for Services

For purposes of determining the eligibility of an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization to receive payment or reimbursement from any federally funded health care program for health care services it furnishes to an Indian, any requirement that the entity be licensed or recognized under State or local law to furnish such services shall be deemed to have been met if the entity meets all the applicable standards for such licensure, but the entity need not obtain a license. In determining whether the entity meets such standards, the absence of licensure of any staff member of the entity may not be taken into account.

§ 409. Consultation

(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP (TAG).—

(1) ESTABLISHMENT AND MEMBERSHIP.—The Secretary shall establish within the Centers for Medicare & Medicaid Services a National Indian Technical Advisory Group (in this subsection referred to as the '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 Secretary may appoint additional members upon the recommendation of the Advisory Group.

(2) DUTIES.—

(A) IDENTIFICATION OF ISSUES.—The Advisory Group shall assist the Secretary in identifying and addressing issues regarding the health care programs under the Social Security Act (including medicare, medicaid, and SCHIP) that have implications for Indian Health Programs or Urban Indian Organizations. The Advisory Group shall provide advice to the Secretary with respect to those issues and with respect to the need for the Secretary to engage in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting any requirement under any applicable Executive order for the Secretary to consult with Indian Tribes in cases of health care policies that have implications for Indian Health Programs or Urban Indian Organizations.

(3) NONAPPLICATION OF FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Group.

(4) MEETINGS.—The Secretary is authorized to convene meetings of the Advisory Group as often as needed to fulfill the responsibilities under this section.

(b) SOLICITATION OF MEDICAID ADVICE.—

(1) IN GENERAL.—As part of its plan for payment under title XIX of the Social Security Act to a State in which the Service operates or funds health care programs or in which 1 or more Indian Health Programs or Urban Indian Organizations provide health care in the State for which medical assistance is available under such title, the State may establish a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of such title to and having a direct effect on such Indian Health Programs and Urban Indian Organizations.

(2) MANNER OF ADVICE.—The process described in paragraph (1) should include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects. Such process may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its medicaid plan.

(3) PAYMENT OF EXPENSES.—Expenses in carrying out this subsection shall be treated as reasonable administrative expenses for which reimbursement may be made under section 1903(a) of the Social Security Act.

(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding existing advisory committees, working groups, or other advisory procedures established by the Secretary or by any State.

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

Notwithstanding any other provision of law, insofar as the State health plan of a State under title XXI of the Social Security Act may provide (whether through its medicaid plan under title XIX of such Act or otherwise) child health assistance to individuals who are otherwise served by the Service or by an Indian Tribe or Tribal Organization, the Secretary may enter into an arrangement with the State and with the Service or 1 or more Indian Tribes and Tribal Organizations in the State under which a portion of the funds otherwise made available to the State under such title with respect to such individuals is provided to the Service, Indian Tribe, or Tribal Organization, respectively, for the purpose of providing such assistance to such individuals consistent with the purposes of such title.

§ 411. Social Security Act Sanctions

(a) REQUESTS FOR WAIVER OF SANCTIONS.—For purposes of applying any authority under a provision of title XI, XVIII, XIX, or XXI of the Social Security Act to seek a waiver of a sanction imposed against a health care provider insofar as that provider provides services to individuals through an Indian Health Program, any requirement that a State request such a waiver shall be deemed to be met if such Indian Health Program requests such a waiver.

(b) SAFE HARBOR FOR TRANSACTIONS BETWEEN AND AMONG INDIAN HEALTH CARE PROGRAMS.—For purposes of applying section 1128B(b) of the Social Security Act, the exchange of anything of value between or among the following shall not be treated as remuneration if the exchange arises from or relates to any of the following health programs:

(1) An exchange between or among the following:

(A) Any Indian Health Program.

(B) Any Urban Indian Organization.

(2) An exchange between an Indian Tribe, Tribal Organization, or an Urban Indian Organization and any patient served or eligible for service from an Indian Tribe, Tribal Organization, or Urban Indian Organization, including patients served or eligible for service pursuant to section 807, but only if such exchange—

(A) is for the purpose of transporting the patient for the provision of health care items or services;

(B) is for the purpose of providing housing to the patient (including a pregnant patient) and immediate family members or an escort incidental to assuring the timely provision of health care items and services to the patient;

(C) is for the purpose of paying premiums, copayments, deductibles, or other cost-sharing on behalf of patients; or

(D) consists of an item or service of small value that is provided as a reasonable incentive to secure timely and necessary preventive and other items and services.

(3) Other exchanges involving an Indian Health Program, an Urban Indian Organization, or an Indian Tribe or Tribal Organization that meet such standards as the Secretary of Health and Human Services, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations and of patients served by Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations.

§ 412. Cost Sharing

(a) COINSURANCE, COPAYMENTS, AND DEDUCTIBLES.—Notwithstanding any other provision of Federal or State law—

(1) PROTECTION FOR ELIGIBLE INDIANS UNDER SOCIAL SECURITY ACT HEALTH PROGRAMS.—No Indian who is furnished an item or service for which payment may be made under title XIX or XXI of the Social Security Act may be charged a deductible, copayment, or coinsurance, if the item or service is furnished by, or upon referral made by, the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

(2) PROTECTION FOR INDIANS.—No Indian who is furnished an item or service by the Service may be charged a deductible, copayment, or coinsurance.

(3) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—The payment or reimbursement due to the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization under title XIX or XXI of the Social Security Act may not be reduced by the amount of the deductible, copayment,

or coinsurance that would be due from the Indian but for the operation of this section.

(b) EXEMPTION FROM MEDICAID AND SCHIP PREMIUMS.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for services under title XIX of the Social Security Act (relating to the medicaid program) or title XXI of such Act (relating to the State children's health insurance program) may be charged a premium as a condition of receiving benefits under the program under the respective title.

(c) LIMITATION ON MEDICAL CHILD SUPPORT RECOVERY.—Notwithstanding any other provision of law, a parent (whether or not an Indian) of an Indian child shall not be responsible for reimbursing a State or the Federal Government under title XIX or XXI of the Social Security Act for the cost of medical services relating to the child (including childbirth and including, where such child is a minor parent, any child of such minor parent) under circumstances in which payment would have been made under the contract health services program of an Indian Health Program but for the child's (or, in the case of medical services relating to childbirth, mother's, or grandchild's as the case may be) eligibility under title XIX or XXI of the Social Security Act.

(d) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID ELIGIBILITY.—Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services under title XIX of the Social Security Act:

(1) Property, including 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 and including public domain allotments.

(2) Property that has unique religious or cultural significance or that supports subsistence or traditional lifestyle according to applicable Tribal law or custom.

(e) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Income, resources, and property that are exempt from medicaid estate recovery under title XIX of the Social Security Act as of April 1, 2003, under manual instructions issued to carry out section 1917(b)(3) of such Act because of Federal responsibility for Indian Tribes and Alaska Native Villages shall remain so exempt. Nothing in this subsection shall be construed as preventing the Secretary from providing additional medicaid estate recovery exemptions for Indians.

§ 413. Treatment Under Medicaid Managed Care.

(a) PAYMENT FOR SERVICES FURNISHED TO INDIANS.—

(1) IN GENERAL.—Subject to paragraph (2), in the case of an Indian who is enrolled with a managed care entity under section 1932 of the Social Security Act (or otherwise under a waiver under title XIX of such Act) and who receives services, covered by a managed care entity, from an Indian Health Program or an Urban Indian Organization, either—

(A) the entity shall make payment to the Indian Health Program or Urban Indian Organization at a rate established by the entity for such services that is not less than the rate for preferred providers (or at such other rate as may be negotiated between the entity and such Indian

Health Program or Urban Indian Organization) and shall not require submittal of a claim by the enrollee as a condition of payment to the Indian Health Program or Urban Indian Organization; or

(B) the State shall provide for payment to the Indian Health Program or Urban Indian Organization under its State plan under title XIX of such Act at the rate otherwise applicable and shall provide for an appropriate adjustment of the capitation payment made to the entity to take into account such payment.

(2) PAYMENT STANDARDS.—The payment provisions shall meet the usual medicaid standards for economy, efficiency, and access to quality care.

(b) OFFERING OF MANAGED CARE.—If—

(1) a State elects under its State plan under title XIX of the Social Security Act to provide services through medicaid managed care organizations or through primary care case managers under section 1932 or under a waiver under such title; and

(2) the Indian Health Program or Urban Indian Organization that is funded in whole or in part by the Service, or a consortium thereof, has established a medicaid managed care organization or a primary care case manager that meets quality standards equivalent to those required of such an organization or manager under such section or waiver,

the State shall enter into an agreement under such section with the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization, or such consortium, to serve as a medicaid managed care organization or a primary care case manager, respectively with respect to Indians served by such entity. In carrying out this subsection, the Secretary and the State may waive requirements regarding enrollment, capitalization, and such other matters that might otherwise prevent the application of the previous sentence.

§ 414. Navajo Nation Medicaid Agency Feasibility Study

(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider the feasibility of—

(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;

(3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity ex-

pends for medical assistance for services and related administrative costs; and

(4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the purposes of title XIX of the Social Security Act (relating to the State children's health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

(c) REPORT.—Not later then 3 years after the date of enactment of the Indian Health Act Improvement Act Amendments of 2004, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Resources and Committee on Ways and Means of the House of Representatives a report that includes—

(1) the results of the study under this section;

(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and

(4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

[§1646. Authorization for emergency contract health services

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

§ 1647. Authorization of [a]*Appropriations*

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* [2000] to carry out this *title* [subchapter].

TITLE V [SUBCHAPTER IV]—HEALTH SERVICES FOR URBAN INDIANS

§ 1651. Purpose

The purpose of this *title* [subchapter] is to establish *and maintain* programs in [u]*U*rban [c]*C*enters to make health services more accessible *and available* to [u]*U*rban Indians.

§ 1652. Contracts [w]*With, and* [g]*Grants to,* [u]*Urban* Indian [o]*Organizations*

Under authority of the Act of November 2, 1921 (25 U.S.C. 13), (*commonly* [popularly] known as the 'Snyder Act'), the Secretary, *acting* through the Service, shall enter into contracts with, or make grants to, [u]*U*rban Indian [o]*O*rganizations to assist such organi-

zations in the establishment and administration, within [the u]*U*rban [c]*C*enters [in which such organizations are situated], of programs which meet the requirements set forth in this *title* [subchapter]. *Subject to section 506, t*[T]he Secretary, *acting* through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this *title* [subchapter] in any contract *into* which the Secretary enters [into] with, or in any grant the Secretary makes to, any *U*[u]rban Indian *O*[o]rganization pursuant to this *title* [subchapter].

§ 1653. Contracts and *G*[g]rants for the *P*[p]rovision of *H*[h]ealth *C*[c]are and *R*[r]eferral *S*[s]ervices

(a) REQUIREMENTS *FOR GRANTS AND CONTRACTS.*—

Under authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] (*commonly* known as the 'Snyder Act'), the Secretary, *acting* through the Service, shall enter into contracts with, or make grants to, [u]*U*rban Indian [o]*O*rganizations for the provision of health care and referral services for [u]*U*rban Indians [residing in the urban centers in which such organizations are situated]. Any such contract or grant shall include requirements that the [u]*U*rban Indian [o]*O*rganization successfully undertake to—

(1) estimate the population of [u]*U*rban Indians residing in the [u]*U*rban [c]*C*enter *or centers that the organization proposes to serve* [in which such organization is situated] who are or could be recipients of health care or referral services;

(2) estimate the current health status of [u]*U*rban Indians residing in such [u]*U*rban [c]*C*enter *or centers*;

(3) estimate the current health care needs of [u]*U*rban Indians residing in such [u]*U*rban [c]*C*enter or centers;

(4) *provide basic health education, including health promotion and disease prevention education, to Urban Indians* [identify all public and private health services resources within such urban center which are or may be available to urban Indians];

(5) *make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of Urban Indians* [determine the use of public and private health services resources by the urban Indians residing in such urban center]; *and*

(6) *where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.* [assist such health services resources in providing services to urban Indians;

[(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

[(8) provide basic health education, including health promotion and disease prevention education, to urban Indians;

[(9) establish and implement training programs to accomplish the referral and education tasks set forth in paragraphs (6) through (8) of this subsection;

[(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

[(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improv-

ing health service programs to meet the needs of urban Indians; and

[(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.]

(b) CRITERIA.—[FOR SELECTION OF ORGANIZATIONS TO ENTER INTO CONTRACTS OR RECEIVE GRANTS]

The Secretary, *acting* through the Service, shall by regulation *adopted pursuant to section 520* prescribe the criteria for selecting [u]*U*rban Indian [o]*O*rganizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

(1) the extent of unmet health care needs of [u]*U*rban Indians in the [u]*U*rban [c]*C*enter *or centers* involved;

(2) the size of the [u]*U*rban Indian population in the [u]*U*rban [c]*C*enter *or centers* involved;

[(3) the accessibility to, and utilization of, health care services (other than services provided under this subchapter) by urban Indians in the urban center involved;]

(3)[(4)] the extent, if any, to which the activities set forth in subsection (a) [of this section] would duplicate *any project funded under this title;*[—]

[(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this subchapter; or

[(B) any project funded under this subchapter;]

(4)[(5)] the capability of an [u]*U*rban Indian [o]*O*rganization to perform the activities set forth in subsection (a) [of this section] and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

(5)[(6)] the satisfactory performance and successful completion by an [u]*U*rban Indian [o]*O*rganization of other contracts with the Secretary under this *title* [subchapter];

(6)[(7)] the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) [of this section] in an [u]*U*rban [c]*C*enter *or centers*; and

(7)[(8)] the extent of existing or likely future participation in the activities set forth in subsection (a) [of this section] by appropriate health and health-related Federal, State, local, and other agencies.

(c) *ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.*—[GRANTS FOR HEALTH PROMOTION AND DISEASE PREVENTION SERVICES]

The Secretary, acting through the Service, shall facilitate access to[,] or provide[,] health promotion and disease prevention services for [u]*U*rban Indians through grants made to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section].

(d) [GRANTS FOR I]*I*MMUNIZATION [S]*S*ERVICES.—

(1) *ACCESS OR SERVICES PROVIDED.*—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for [u]*U*rban Indians through grants made to [u]*U*rban Indian [o]*O*rganizations administering con-

tracts entered into [pursuant to this section] or receiving grants under [subsection (a) of] this section.

(2) DEFINITION.—For purposes of this subsection, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

[(2) In making any grant to carry out this subsection, the Secretary shall take into consideration—

[(A) the size of the urban Indian population to be served;

[(B) the immunization levels of the urban Indian population, particularly the immunization levels of infants, children, and the elderly;

[(C) the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population; and

[(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.

[(3) For purposes of this subsection, the term "immunization services" means services to provide without charge immunizations against vaccine-preventable diseases.]

(e) *BEHAVIORAL* [GRANTS FOR PROVISION OF MENTAL H]*H*EALTH [S]*S*ERVICES.—

(1) *ACCESS OR SERVICES PROVIDED.*—The Secretary, acting through the Service, shall facilitate access to, or provide, *behavioral* [mental] health services for [u]*U*rban Indians through grants made to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section].

(2) *ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a* [A] grant may not be made under this subsection to an [u]*U*rban Indian [o]*O*rganization until that organization has prepared, and the Service has approved, an assessment of the *following:* [mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.]

(A) The behavioral health needs of the Urban Indian population concerned.

(B) The behavioral health services and other related resources available to that population.

(C) The barriers to obtaining those services and resources.

(D) The needs that are unmet by such services and resources.

(3) *PURPOSES OF GRANTS.*—Grants may be made under this subsection[—] *for the following:*

(A) [t]*T*o prepare assessments required under paragraph (2)[;].

(B) [t]*T*o provide outreach, educational, and referral services to [u]*U*rban Indians regarding the availability of direct *behavioral* [mental] health services, to educate [u]*U*rban Indians about *behavioral* [mental] health issues and services, and effect coordination with existing

behavioral [mental] health providers in order to improve services to [u]*U*rban Indians[;].

(C) [t]*T*o provide outpatient *behavioral* [mental] health services to [u]*U*rban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.[; and]

(D) [t]*T*o develop innovative *behavioral* [mental] health service delivery models which incorporate Indian cultural support systems and resources.

(f) [GRANTS FOR P]*P*REVENTION [AND TREATMENT] OF [C]*C*HILD [A]ABUSE

(1) *ACCESS OR SERVICES PROVIDED*.—The Secretary, acting through the Service, shall facilitate access to[,] or provide[,] services for [u]*U*rban Indians through grants to [u]*U*rban Indian [o]*O*rganizations administering contracts entered into [pursuant to this section] or receiving grants under subsection (a) [of this section] to prevent and treat child abuse (including sexual abuse) among [u]*U*rban Indians.

(2) *EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a* [A] grant may not be made under this subsection to an [u]*U*rban Indian [o]*O*rganization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the [u]*U*rban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

(3) *PURPOSES OF GRANTS*.—Grants may be made under this subsection[—] *for the following:*

(A) [t]*T*o prepare assessments required under paragraph (2)[;].

(B) [f]*F*or the development of prevention, training, and education programs for [u]*U*rban Indian*s* [populations], including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection.[; and]

(C) [t]*T*o provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to [u]*U*rban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to [u]*U*rban Indian perpetrators of child abuse (including sexual abuse).

(4) *CONSIDERATIONS WHEN MAKING GRANTS*.—In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the support for the [u]*U*rban Indian [o]*O*rganization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

(B) the capability and expertise demonstrated by the [u]*U*rban Indian [o]*O*rganization to address the complex problem of child sexual abuse in the community; and

(C) the assessment required under paragraph (2).

(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an Urban Indian Organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

§ 1654. Contracts and [g]*G*rants for *the* [d]*D*etermination of [u]*U*nmet [h]*H*ealth [c]*C*are [n]*N*eeds

(a) *GRANTS AND CONTRACTS AUTHORIZED*.—[AUTHORITY]

Under authority of the Act of November 2, 1921 (25 U.S.C. 13)[, popularly] *(commonly* known as the 'Snyder Act'*)*, the Secretary, *acting* through the Service, may enter into contracts with[,] or make grants to[, u]*U*rban Indian [o]*O*rganizations situated in [u]*U*rban [c]*C*enters for which contracts have not been entered into[,] or grants have not been made[,] under section *503* [1653 of this title].

(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection *(c)*[(b)](1) [of this section] in order to assist the Secretary in assessing the health status and health care needs of [u]*U*rban Indians in the [u]*U*rban [c]*C*enter involved and determining whether the Secretary should enter into a contract or make a grant under section *503*[1653 of this title] with respect to the [u]*U*rban Indian [o]*O*rganization which the Secretary has entered into a contract with, or made a grant to, under this section.

(c) [(b)] *GRANT AND CONTRACT* REQUIREMENTS.—

Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

(1) the [u]*U*rban Indian [o]*O*rganization successfully undertakes to—

(A) document the health care status and unmet health care needs of [u]*U*rban Indians in the [u]*U*rban [c]*C*enter involved; and

(B) with respect to [u]*U*rban Indians in the [u]*U*rban [c]*C*enter involved, determine the matters described in *paragraphs* [clauses] (2), (3), (4), and *(7)*[(8)] of section *503(b)* [1653(b) of this title]; and

(2) the [u]*U*rban Indian [o]*O*rganization complete performance of the contract, or carry out the requirements of the grant, within *1*[one] year after the date on which the Secretary and such organization enter into such contract, or within *1*[one] year after such organization receives such grant, whichever is applicable.

(d) [(c)] *NO* RENEWALS

The Secretary may not renew any contract entered into[,] or grant made[,] under this section.

§ 1655. Evaluations; [r]*R*enewals

(a) *PROCEDURES FOR EVALUATIONS*.—[CONTRACT COMPLIANCE AND PERFORMANCE]

The Secretary, *acting* through the Service, shall develop procedures to evaluate compliance with grant requirements [under this subchapter] and compliance with[,] and performance of contracts entered into by [u]*U*rban Indian [o]*O*rganizations under this *title* [subchapter]. Such procedures shall include provisions for carrying out the requirements of this section.

(b) [ANNUAL ONSITE E]*E*VALUATIONS

The Secretary, *acting* through the Service, shall *evaluate the compliance* [conduct an annual onsite evaluation] of each [u]*U*rban Indian [o]*O*rganization which has entered into a contract or received a grant under section *503 with the terms of* [1653 of this title for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract or the terms of] such *contract or grant. For purposes of this evaluation, in determining the capacity of an Urban Indian Organization to deliver quality patient care the Secretary shall—*

(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

(2) accept in lieu of such onsite evaluation evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

(c) NONCOMPLIANCE; [OR U]*U*NSATISFACTORY [P]*P*ERFORMANCE.—

If, as a result of the evaluations conducted under this section, the Secretary determines that an [u]*U*rban Indian [o]*O*rganization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section *503*[1653 of this title], the Secretary shall, prior to renewing such contract or grant, attempt to resolve with *the* [such] organization the areas of noncompliance or unsatisfactory performance and modify *the* [such] contract or grant to prevent future occurrences of [such] noncompliance or unsatisfactory performance. If the Secretary determines that *the* [such] noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew *the* [such] contract or grant with *the* [such] organization and is authorized to enter into a contract or make a grant under section *503* [1653 of this title] with another [u]*U*rban Indian [o]*O*rganization which is situated in the same [u]*U*rban [c]*C*enter as the [u]*U*rban Indian [o]*O*rganization whose contract or grant is not renewed under this section.

(d) *CONSIDERATIONS FOR* [CONTRACT AND GRANT R]*R*ENEWALS

In determining whether to renew a contract or grant with an [u]*U*rban Indian [o]*O*rganization under section *503* [1653 of this title] which has completed performance of a contract or grant under section *504* [1654 of this title], the Secretary shall review the records of the [u]*U*rban Indian [o]*O*rganization, the reports submitted under section *507* [1657 of this title, and, in the case of a renewal of a contract or grant under section 1653 of this title], and shall consider the results of the onsite evaluations *or accreditations* [conducted] under subsection (b) [of this section].

§ 1656. Other [c]*C*ontract and [g]*G*rant [r]*R*equirements

(a) *PROCUREMENT*.—[FEDERAL REGULATIONS; EXCEPTIONS]

Contracts with [u]*U*rban Indian [o]*O*rganizations entered into pursuant to this *title* [subchapter] shall be in accordance with all Federal contracting laws and regulations *relating to procurement* except that[,] in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of sections *1304 and 3131 through* [3131 to] 3133 of [T]*t*itle 40, *United States Code.*

(b) PAYMENT *UNDER CONTRACTS OR GRANTS*.—

Payments under any contracts or grants pursuant to this *title shall, notwithstanding any term or condition of such contract or grant*—[subchapter may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this subchapter.]

(1) be made in their entirety by the Secretary to the Urban Indian Organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

(2) if any portion thereof is unexpended by the Urban Indian Organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the availability for expenditure of such funds.

(c) REVISION OR [A]*A*MENDMENT *OF CONTRACTS*.—

Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an [u]*U*rban Indian [o]*O*rganization, revise or amend any contract entered into by the Secretary with such organization under this *title* [subchapter] as necessary to carry out the purposes of this *title* [subchapter].

[(d) EXISTING GOVERNMENT FACILITIES

[In connection with any contract or grant entered into pursuant to this subchapter, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract or grant, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.]

(d) FAIR AND [(e)] UNIFORM [PROVISION OF S]*S*ERVICES AND [A]*A*SSISTANCE.—

Contracts with[,] or grants to[, u]*U*rban Indian [o]*O*rganizations and regulations adopted pursuant to this *title* [subchapter] shall include provisions to assure the fair and uniform provision to [u]*U*rban Indians of services and assistance under such contracts or grants by such organizations.

[(f) ELIGIBILITY FOR HEALTH CARE OR REFERRAL SERVICES

[Urban Indians, as defined in section 1603(f) of this title, shall be eligible for health care or referral services provided pursuant to this subchapter.]

§ 1657. Reports and [r]*R*ecords

(a) [QUARTERLY R]*R*EPORTS.—

For each fiscal year during which an [u]*U*rban Indian [o]*O*rganization receives or expends funds pursuant to a contract entered into[,] or a grant received[,] pursuant to this *title* [subchapter], such *Urban Indian O*[o]rganization shall submit to the Secretary *not more frequently than every 6 months,* a [quarterly] report *that includes the following:* [including—]

(1) [i]*I*n the case of a contract or grant under section *503, recommendations pursuant to section 503(a)(5).* [1653 of this title, information gathered pursuant to clauses (10) and (11) of this subsection (a) of such section;]

(2) [i]*I*nformation on activities conducted by the organization pursuant to the contract or grant[;].

(3) [a]An accounting of the amounts and purpose[s] for which Federal funds were expended.[; and]

(4) *A minimum set of data, using uniformly defined elements, that is specified by the Secretary in consultation, consistent with section 514, with Urban Indian Organizations.* [such other information as the Secretary may request.]

(b) AUDIT [BY SECRETARY AND COMPTROLLER GENERAL].—

The reports and records of the [u]*U*rban Indian [o]*O*rganization with respect to a contract or grant under this *title* [subchapter] shall be subject to audit by the Secretary and the Comptroller General of the United States.

(c) COST OF [ANNUAL PRIVATE A]*A*UDITS.—

The Secretary shall allow as a cost of any contract or grant entered into *or awarded* under section *502 or 503* [1653 of this title] the cost of an annual *independent financial* [private] audit conducted by—

(1) a certified public accountant[.]*; or*

(2) a certified public accounting firm qualified to conduct Federal compliance audits.

[(d) HEALTH STATUS, SERVICES, AND AREAS OF UNMET NEEDS; CHILD WELFARE

[(1) The Secretary, acting through the Service, shall submit a report to the Congress not later than March 31, 1992, evaluating—

[(A) the health status of urban Indians;

[(B) The services provided to Indians through this subchapter;

[(C) areas of unmet needs in urban areas served under this subchapter; and

[(D) areas of unmet needs in urban areas not served under this subchapter.

[(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

[(3) The Secretary and the Secretary of the Interior shall—

[(A) assess the status of the welfare of urban Indian children, including the volume of child protection cases, the prevalence of child sexual abuse, and the extent of urban Indian coordination with tribal authorities with respect to child sexual abuse; and

[(B) submit a report on the assessment required under subparagraph (A), together with recommended legislation to improve Indian child protection in urban Indian populations, to the Congress no later than March 31, 1992.]

§ 1658. Limitation on [c]*Contract* [a]*Authority*

The authority of the Secretary to enter into contracts *or to award grants* under this *title* [subchapter] shall be to the extent, and in an amount, provided for in appropriation Acts.

§ 1659. Facilities [renovation]

(a) GRANTS.—The Secretary, *acting through the Service,* may make *grants* [funds available] to contractors or grant recipients under this *title* [subchapter] for the *lease, purchase, renovation, construction, or expansion of* [minor renovations to] facilities, including leased facilities, *in order* to assist such contractors or grant recipients in *complying with applicable licensure or certification requirements* [meeting or maintaining the Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards].

(b) LOANS.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide to contractors or grant recipients under this title loans from the Urban Indian Health Care Facilities Revolving Loan Fund 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 of the principal of loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation 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 Urban Indian 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) 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 (hereafter in this section referred to as the 'URLF'). 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 AMOUNT IN FUND.—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) INVESTMENT OF AMOUNTS IN FUND.—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.

(4) INITIAL FUNDS.—There are authorized to be appropriated such sums as may be necessary to initiate the URLF. For each fiscal year after the initial year in which funds are appropriated to the URLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the URLF during the preceding fiscal year and all accrued interest.

§ 1660. *Office of* Urban *Indian* Health [Programs Branch]

[(a) ESTABLISHMENT]

There is hereby established within the Service *an Office* [a Branch] of Urban *Indian* Health, [Programs] which shall be responsible for—

(1) carrying out the provisions of this *title;* [subchapter and for]

(2) providing central oversight of the programs and services authorized under this *title; and* [subchapter.]

(3) providing technical assistance to Urban Indian Organizations.

[(b) STAFF, SERVICES, AND EQUIPMENT

[The Secretary shall appoint such employees to work in the branch, including a program director, and shall provide such services and equipment, as may be necessary for it to carry out its responsibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request.]

§ 1660a. Grants for [a]*A*lcohol and [s]*S*ubstance [a]*A*buse [r]*R*elated [s]*S*ervices

(a) GRANTS *AUTHORIZED.*—

The Secretary*, acting through the Service,* may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education *regarding* [in], alcohol and substance abuse in [u]*U*rban [c]*C*enters to those [u]*U*rban Indian [o]*O*rganizations with *which* [whom]

the Secretary has entered into a contract under this *title* [subchapter] or under section *201* [1621 of this title].

(b) GOALS [OF GRANT].—

Each grant made pursuant to subsection (a) [of this section] shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—

The Secretary shall establish criteria for the grants made under subsection (a) [of this section], including criteria relating to the *following:*[—]

(1) *The* size of the [u]*U*rban Indian population[;].

[(2) accessibility to, and utilization of, other health resources available to such population;

[(3) duplication of existing Service or other Federal grants or contracts;]

(2)[(4) c]*C*apability of the organization to adequately perform the activities required under the grant[;].

(3)[(5) s]*S*atisfactory performance standards for the organization in meeting the goals set forth in such grant.[, which] *The* standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis.[; and]

(4)[(6) i]*I*dentification of need for services.

(d) ALLOCATION OF GRANTS.—The Secretary shall develop a methodology for allocating grants made pursuant to this section based on *the* [such] criteria *established pursuant to subsection (c).*

(e)[(d)] *GRANTS SUBJECT TO CRITERIA.*—[TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS]

Any funds received by an [u]*U*rban Indian [o]*O*rganization under this *Act* [chapter] for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c) [of this section].

§ 1660b. Treatment of [c]*C*ertain [d]*D*emonstration [p]*P*rojects.

[(a)] Notwithstanding any other provision of law, the *Tulsa Clinic and* Oklahoma City Clinic demonstration projects *shall*—[and the Tulsa Clinic demonstration project shall be treated as service units in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.]

(1) be permanent programs within the Service's direct care program;

(2) continue to be treated as Service Units in the allocation of resources and coordination of care; and

(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

[(b) The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 1671 of this title for fiscal year 1999, a report on the findings and

conclusions derived from the demonstration projects specified in subsection (a) of this section.

[(c) In addition to the amounts made available under section 1660d of this title to carry out this section through fiscal year 2000, there are authorized to be appropriated such sums as may be necessary to carry out this section for each of fiscal years 2001 and 2002.]

§ 1660c. Urban NIAAA [t]*T*ransferred [p]*P*rograms

(a) *GRANTS AND CONTRACTS.*—[DUTY OF SECRETARY]

The Secretary*, through the Office* [shall, within the Branch] of Urban *Indian* Health, *shall* [Programs of the Service,] make grants or enter into contracts *with Urban Indian Organizations* for the administration of [u]*U*rban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as "NIAAA") and transferred to the Service. *Such grants and contracts shall become effective no later than September 30, 2007.*

(b) USE OF *FUNDS.*—[GRANTS]

Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for [u]*U*rban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

(c) ELIGIBILITY.—[FOR GRANTS]

Urban Indian [o]*O*rganizations that operate Indian alcohol programs originally funded under *the* NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

[(d) COMBINATION OF FUNDS

[For the purpose of carrying out this section, the Secretary may combine NIAAA alcohol funds with other substance abuse funds currently administered through the Branch of Urban Health Programs of the Service.]

(d)[(e) EVALUATION AND R]*R*EPORT.—[TO CONGRESS]

The Secretary shall evaluate and report to [the] Congress on the activities of programs funded under this section *not less than* [at least] every 5 years.

§ 514. Consultation with Urban Indian Organizations

(a) IN GENERAL.—The Secretary shall ensure that the Service consults, to the greatest extent practicable, with Urban Indian Organizations.

(b) DEFINITION OF CONSULTATION.—For purposes of subsection (a), consultation is the open and free exchange of information and opinions which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

§ 515. Federal Tort Claim Act Coverage

(a) IN GENERAL.—With respect to claims resulting from the performance of functions during fiscal year 2004 and thereafter, or claims asserted after September 30, 2003, but resulting from the performance of functions prior to fiscal year 2004, under a contract, grant agreement, or any other agreement authorized under this title, an Urban Indian Organization is deemed hereafter to be part of the

Service in the Department of Health and Human Services while carrying out any such contract or agreement and its employees are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or agreement. After September 30, 2003, any civil action or proceeding involving such claims brought hereafter against any Urban Indian Organization or any employee of such Urban Indian Organization covered by this provision shall be deemed to be an action against the United States and will be defended by the Attorney General and be afforded the full protection and coverage of the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.).

(b) CLAIMS RESULTING FROM PERFORMANCE OF CONTRACT OR GRANT.—Beginning with the fiscal year ending September 30, 2003, and thereafter, the Secretary shall request through annual appropriations funds sufficient to reimburse the Treasury for any claims paid in the prior fiscal year pursuant to the foregoing provisions.

§ 516. Urban Youth Treatment Center Demonstration

(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, through grant or contract, is authorized to fund the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

(b) DEFINITION OF STATE.—A State described in this subsection is a State in which—

(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and

(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

§ 517. Use of Federal Property and Supplies

(a) AUTHORIZATION FOR USE.—The Secretary, acting through the Service, shall allow an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other real and personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

(c) ACQUISITION OF PROPERTY FOR DONATION.—The Secretary may acquire excess or surplus government personal or real property for donation (subject to subsection (d)), to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the Urban Indian Organization for a purpose for which a contract or grant is authorized under this title.

(d) PRIORITY.—In the event that the Secretary receives a request for donation of a specific item of personal or real property described in subsection (b) or (c) from both an Urban Indian Organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation of the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically to the Urban Indian Organization.

(e) URBAN INDIAN ORGANIZATIONS DEEMED EXECUTIVE AGENCY FOR CERTAIN PURPOSES.—For purposes of section 501 of title 40, United States Code, (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, 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.

§ 518. Grants for Diabetes Prevention, Treatment, and Control

(a) GRANTS AUTHORIZED.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

(1) the size and location of the Urban Indian population to be served;

(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served;

(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

(4) the capability of the organization to adequately perform the activities required under the grant; and

(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

§ 519. Community Health Representatives

The Secretary, acting through the Service, may enter into contracts with, and make grants to, Urban Indian Organizations for

the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to Urban Indians.

§ 520. Regulations

(a) REQUIREMENTS FOR REGULATIONS.—The Secretary may promulgate regulations to implement the provisions of this title in accordance with the following:

(1) Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 9 months after the date of the enactment of this Act and shall have no less than a 4–month comment period.

(2) The authority to promulgate regulations under this Act shall expire 18 months from the date of the enactment of this Act.

(b) EFFECTIVE DATE OF TITLE.—The amendments to this title made by the Indian Health Care Improvement Act Amendments of 2004 shall be effective on the date of the enactment of such amendments, regardless of whether the Secretary has promulgated regulations implementing such amendments have been promulgated.

§ 521. Eligibility for Services

Urban Indians shall be eligible and the ultimate beneficiaries for health care or referral services provided pursuant to this title.

§ 1660d. Authorization of [a]*A*ppropriations

There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year *2015* [2000] to carry out this *title* [subchapter].

TITLE VI [SUBCHAPTER V]— ORGANIZATIONAL IMPROVEMENTS

§ 1661. Establishment of *the* Indian Health Service as an *A*[a]gency of *the* Public Health Service

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian [t]*T*ribes, as are or may be *hereafter* [on and after November 23, 1988,] provided by Federal statute or treaties, there is established within the Public Health Service of the Department [of Health and Human Services] the Indian Health Service.

(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The [Indian Health] Service shall be administered by *an Assistant Secretary of Indian Health* [a Director], who shall be appointed by the President, by and with the advice and consent of the Senate. The *Assistant Secretary* [Director of the Indian Health Service] shall report to the Secretary. [through the Assistant Secretary for Health of the Department of Health and Human Services.] Effective with respect to an individual appointed by the President, by and with the advice and consent of the Sen-

ate, after January 1, *2005*[1993], the term of service of the *Assistant Secretary* [Director] shall be 4 years. An *Assistant Secretary* [A Director] may serve more that 1 term.

(3) INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2004 shall serve as Assistant Secretary.

(4) ADVOCACY AND CONSULTATION.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

(A) facilitate advocacy for the development of appropriate Indian health policy; and

(B) promote consultation on matters relating to Indian health.

(b) AGENCY.—[STATUS]

The [Indian Health] Service shall be an agency within the Public Health Service of the Department [of Health and Human Services], and shall not be an office, component, or unit of any other agency of the Department.

(c) DUTIES.—

The *Assistant* Secretary [shall carry out through the Director] of [the] Indian Health [Service] *shall—*

(1) *perform* all functions *that* [which] were, on the day before *the date of enactment of the Indian Health Care Improvement Act Amendments of 2004*, [November 23, 1988,] carried out by or under the direction of the individual serving as Director of the Indian Health Service on *that* [such] day;

(2) *perform* all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

(3) *administer* all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including [(but not limited to)] programs under—

(A) this *Act* [chapter];

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

(E) the Indian Self-Determination *and Education Assistance* Act (25 U.S.C. 450[f] et seq.); [and]

(4) *administer* all scholarship and loan functions carried out under *title* [subchapter] I [of this chapter.];

(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

(9) coordinate the activities of the Department concerning matters of Indian health; and

(10) perform such other functions as the Secretary may designate.

(d) AUTHORITY.—[OF SECRETARY]

(1) *IN GENERAL*.—The Secretary, acting through the *Assistant Secretary* [Director of the Indian Health Service], shall have the authority—

(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with [T]*t*itle 5, *United States Code*;

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

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

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

(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any Federal law, Executive order, rule, regulation, or delegation of authority, or in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

§1662. Automated [m]*M*anagement [i]*I*nformation [s]*S*ystem

(a) ESTABLISHMENT.—

(1) *IN GENERAL*.—The Secretary shall establish an automated management information system for the Service.

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

(A) a financial management system[,]*;*

(B) a patient care information system for each area served by the [s]Service[,]*;*

(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service[, and]*;*

(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each [a]*A*rea office of the Service[.]*;*

(E) an interface mechanism for patient billing and accounts receivable system; and

(F) a training component.

(b) PROVISION *OF SYSTEMS* to [INDIAN T]*T*RIBES AND [o]*O*RGANIZATIONS.—[; REIMBURSEMENT]

[(1)] The Secretary shall provide each *Tribal Health Program* [Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian

Self-Determination Act [25 U.S.C.A. §450f et seq.]] automated management information systems which—

(1)[(A)] meet the management information needs of such *Tribal Health Program* [Indian tribe or tribal organization] with respect to the treatment by the *Tribal Health Program* [Indian tribe or tribal organization] of patients of the Service[,]; and

(2)[(B)] meet the management information needs of the Service.

[(2) The Secretary shall reimburse each Indian tribe or tribal organization for the part of the cost of the operation of a system provided under paragraph (1) which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Service.

[(3) The Secretary shall provide systems under paragraph (1) to Indian tribes and tribal organizations providing health services in California by no later than September 30, 1990.]

(c) ACCESS TO RECORDS.—

Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

§ 603. Authorization of Appropriations

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

TITLE VII—BEHAVIORAL HEALTH [SUBCHAPTER V–A—SUBSTANCE ABUSE] PROGRAMS

§ 701. Behavioral Health Prevention and Treatment Services

(a) PURPOSES.—The purposes of this section are as follows:

(1) To authorize and direct the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavior health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

(b) PLANS.—

(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

(ii) an estimate of the financial and human cost attributable to such illness or behavior.

(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to meet their responsibilities under the plans.

(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, Urban Indian Organization, or the Service.

(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

(c) PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, to the extent feasible and if funding is available, programs including the following:

(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

(B) detoxification (social and medical);

(C) acute hospitalization;

(D) intensive outpatient/day treatment;

(E) residential treatment;

(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

(G) emergency shelter;

(H) intensive case management;

(I) Traditional Health Care Practices; and

(J) diagnostic services.

(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

(C) identification and treatment of co-occurring disorders and comorbidity;

(D) prevention of alcohol, drug, inhalant, and tobacco use;

(E) early intervention, treatment, and aftercare;

(F) promotion of healthy choices and lifestyle (related to sexually transmitted diseases, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk/safety issues); and

(G) identification and treatment of neglect and physical, mental, and sexual abuse.

(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including gender specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of gender specific healthy choices and lifestyle (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk-related behavior);

(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

(F) gender specific treatment for sexual assault and domestic violence.

(4) FAMILY CARE.—Behavioral health services for families, including—

(A) early intervention, treatment, and aftercare for affected families;

(B) treatment for sexual assault and domestic violence; and

(C) promotion of healthy choices and lifestyle (related to parenting, partners, domestic violence, and other abuse issues).

(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

(A) early intervention, treatment, and aftercare;

(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including gender specific services;

(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

(D) promotion of healthy choices and lifestyle (managing conditions related to aging);

(E) gender specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

(F) identification and treatment of dementias regardless of cause.

(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization in the development and implementation of such plan.

(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

(f) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, 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 conver-

sion of existing, underused Service hospital beds into psychiatric units to meet such need.

§ 702. Memoranda of Agreement with the Department of the Interior

[§ 1665. Indian Health Service responsibilities]

(a) CONTENTS.—Not later than 12 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

(B) The right of Indians to participate in, and receive the benefit of, such services.

(C) The actions necessary to protect the exercise of such right.

(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service

Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

(b) SPECIFIC PROVISIONS REQUIRED.—The **[**Memorandum**]** *memoranda* of **[**A**]***a*greement *updated* or entered into pursuant to *subsection (a)* **[**section 2411 of this title**]** 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 Indians **[**people**]**, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

(c) CONSULTATION.—The Secretary, acting through the Service, and the Secretary of the Interior shall, in developing the memoranda of agreement under subsection (a), consult with and solicit the comments from—

(1) Indian Tribes and Tribal Organizations;

(2) Indians;

(3) Urban Indian Organizations and other Indian organizations; and

(4) behavioral health service providers.

(d) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereof) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and Urban Indian Organization.

[§ 1665a. Indian Health Service program]

§ 703. [(a)] Comprehensive *Behavioral Health* [p]*P*revention and [t]*T*reatment [p]*P*rogram

(a) ESTABLISHMENT.—

(1) *IN GENERAL.*—The Secretary, acting through the Service, *Indian Tribes, and Tribal Organizations,* shall provide a program of comprehensive *behavioral health,* **[**alcohol and substance abuse**]** prevention, **[**and**]** treatment, *and aftercare, including Traditional Health Care Practices,* which shall include—

(A) prevention, through educational intervention, in Indian communities;

(B) acute detoxification, *psychiatric hospitalization, residential, and intensive outpatient* [and] treatment;

(C) community-based rehabilitation *and aftercare*;

(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; [and]

(E) *specialized* residential treatment programs for *high-risk populations, including but not limited to* pregnant and *postpartum* [post partum] women and their children[.]*; and*

(F) diagnostic services.

(2) *TARGET POPULATIONS.*—The target population of such programs shall be members of Indian [t]*T*ribes. Efforts to train and educate key members of the Indian community shall *also* target employees of health, education, judicial, law enforcement, legal, and social service programs.

(b) CONTRACT [H]*H*EALTH [S]*S*ERVICES

(1) *IN GENERAL.*—The Secretary, acting through the Service, *Indian Tribes, and Tribal Organizations,* may enter into contracts with public or private providers of *behavioral health* [alcohol and substance abuse] treatment services for the purpose of [assisting the Service in] carrying out the program required under subsection (a) [of this section].

(2) *PROVISION OF ASSISTANCE.*—In carrying out this subsection, the Secretary shall provide assistance to Indian [t]*T*ribes *and Tribal Organizations* to develop criteria for the certification of *behavioral health* [alcohol and substance abuse] service providers and accreditation of service facilities which meet minimum standards for such services and facilities [as may be determined pursuant to section 2411(a)(3) of this title].

§ 704. Mental Health Technician Program

(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), the Secretary shall establish and maintain a mental health technician program within the Service which—

(1) provides for the training of Indians as mental health technicians; and

(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

(b) PARAPROFESSIONAL TRAINING.—In carrying out subsection (a), the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

(c) SUPERVISION AND EVALUATION OF TECHNICIANS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Orga-

nizations, shall supervise and evaluate the mental health technicians in the training program.

(d) TRADITIONAL HEALTH CARE PRACTICES.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served.

[(c) GRANTS FOR MODEL PROGRAM

[(1) The Secretary, acting through the Service shall make a grant to the Standing Rock Sioux Tribe to develop a community-based demonstration project to reduce drug and alcohol abuse on the Standing Rock Sioux Reservation and to rehabilitate Indian families afflicted by such abuse.

[(2) Funds shall be used by the Tribe to—

[(A) develop and coordinate community-based alcohol and substance abuse prevention and treatment services for Indian families;

[(B) develop prevention and intervention models for Indian families;

[(C) conduct community education on alcohol and substance abuse; and

[(D) coordinate with existing Federal, State, and tribal services on the reservation to develop a comprehensive alcohol and substance abuse program that assists in the rehabilitation of Indian families that have been or are afflicted by alcoholism.

[(3) The Secretary shall submit to the President for inclusion in the report to be transmitted to the Congress under section 1671 of this title for fiscal year 1995 an evaluation of the demonstration project established under paragraph (1).]

§ 705. Licensing Requirement for Mental Health Care Workers

Subject to the provisions of section 221, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act or through a Funding Agreement shall be licensed as a clinical psychologist, social worker, or marriage and family therapist, respectively, or working under the direct supervision of a licensed clinical psychologist, social worker, or marriage and family therapist, respectively.

§ 1665b. Indian [w]*W*omen [t]*T*reatment [p]*P*rograms

(a) *FUNDING.*—[GRANTS]

The Secretary, *consistent with section 701, shall* [may] make grants to Indian [t]*T*ribes, [and t]*T*ribal [o]*O*rganizations, *and Urban Indian Organizations* to develop and implement a comprehensive *behavioral health* [alcohol and substance abuse] program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the *spiritual,* cultural, historical, social, and child care needs of Indian women, regardless of age.

(b) USE OF *FUNDS.*—[GRANTS]

Funds [Grants] made *available* pursuant to this section may be used to—

(1) develop and provide community training, education, and prevention programs for Indian women relating to *behavioral health* [alcohol and substance abuse] issues, including fetal alcohol *disorders* [syndrome and fetal alcohol effect];

(2) identify and provide *psychological services,* [appropriate] counseling, advocacy, support, and relapse prevention to Indian women and their families; and

(3) develop prevention and intervention models for Indian women which incorporate [t]*T*raditional *Health Care Practices* [healers], cultural values, and community and family involvement.

(c) CRITERIA.—[FOR REVIEW AND APPROVAL OF GRANT APPLICATIONS]

The Secretary*, in consultation with Indian Tribes and Tribal Organizations*, shall establish criteria for the review and approval of applications *and proposals for funding* [grants] under this section.

(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations.

[(d) AUTHORIZATION OF APPROPRIATIONS

[(1) There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 1993 and such sums as are necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

[(2) Twenty percent of the funds appropriated pursuant to this subsection shall be used to make grants to urban Indian organizations funded under subchapter IV of this chapter.]

§1665c. Indian [Health Service y]*Youth* [p]*Program*

(a) DETOXIFICATION AND [R]*R*EHABILITATION.—

The Secretary*, acting through the Service, consistent with section 701,* shall develop and implement a program for acute detoxification and treatment for Indian youths, *including behavioral health services* [who are alcohol and substance abusers]. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis *and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian Self-Determination and Education Assistance Act*. [These r]*R*egional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

(b) *ALCOHOL AND SUBSTANCE ABUSE* TREATMENT [C]*C*ENTERS OR [F]*F*ACILITIES

(1) ESTABLISHMENT.—

[(1)]*(A) IN GENERAL.*—The Secretary*, acting through the Service, Indian Tribes, and Tribal Organizations,* shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, *at least 1*[a] youth regional treatment center *or treatment network* in each area under the jurisdiction of an [a]*A*rea [o]*O*ffice.

(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the [area offices of the Service in Tucson and Phoenix, Arizona, shall be considered one area office and the a]*A*rea [o]*O*ffice in California shall be considered to be *2* [two a]*A*rea [o]*O*ffices, *1*[one] office whose juris-

diction shall be considered to encompass the northern area of the State of California, and *1*[one] office whose jurisdiction shall be considered to encompass the remainder of the State of *California for the purpose of implementing California treatment networks*.

(2) *FUNDING*.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

(3) *LOCATION*.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority *of the Indian T*[t]ribes to be served by such center.

(4) *SPECIFIC PROVISION OF FUNDS*.—

(A) *IN GENERAL*.—Notwithstanding any other provision of this *title* [subchapter], the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

(i) The Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4[50b](*1*) of *the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l))* [this title].

(B) *PROVISION OF SERVICES TO ELIGIBLE YOUTHS*.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska [such State].

(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services, which may incorporate Traditional Health Care Practices, to Indian children and adolescents, including—

(A) pretreatment assistance;

(B) inpatient, outpatient, and aftercare services;

(C) emergency care;

(D) suicide prevention and crisis intervention; and

(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) USE OF FUNDS.—Funds provided under this subsection may be used—

(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

(B) to hire behavioral health professionals;

(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional

housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

(E) for intensive home-and community-based services.

(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

(d)[(c)] FEDERALLY [O]*O*WNED [S]*S*TRUCTURES.—

(1) *IN GENERAL*.—The Secretary, [acting through the Service, shall,] in consultation with Indian [t]*T*ribes *and Tribal Organizations, shall—*

(A) identify and use, where appropriate, federally owned structures suitable *for* [as] local residential or regional *behavioral health* [alcohol and substance abuse] treatment [centers] for Indian youths; and

(B) establish guidelines*, in consultation with Indian Tribes and Tribal Organizations*, for determining the suitability of any such federally owned structure to be used *for* [as a] local residential or regional *behavioral health* [alcohol and substance abuse] treatment [center] for Indian youths.

(2) *TERMS AND CONDITIONS FOR USE OF STRUCTURE*.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure *and any Indian Tribe or Tribal Organization operating the program*.

(e)[(d)] REHABILITATION AND [A]*A*FTERCARE [S]*S*ERVICES

(1) *IN GENERAL*.—The Secretary, *Indian Tribes, or Tribal Organizations*, in cooperation with the Secretary of the Interior, shall develop and implement within each Service [service u]*U*nit, community-based rehabilitation and follow-up services for Indian youths who are *having significant behavioral health problems and require* [alcohol or substance abusers which are designed to integrate] long-term treatment, *community reintegration*, and *monitoring* to [monitor and] support the Indian youths after their return to their home community.

(2) *ADMINISTRATION*.—Services under paragraph (1) shall be provided [administered within each service unit] by trained staff within the community who can assist the Indian youths in *their* continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff *may* [shall] include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

(f)[(e)] INCLUSION OF [F]*F*AMILY IN [Y]*Y*OUTH [T]*T*REATMENT [P]*P*ROGRAM

In providing the treatment and other services to Indian youths authorized by this section, the Secretary*, acting through the Service, Indian Tribes, and Tribal Organizations*, shall provide for the inclusion of family members of such youths in the treatment pro-

grams or other services as may be appropriate. Not less that 10 percent of the funds appropriated for the purposes of carrying out subsection *(e)*[(d) of this section] shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

(g)[(f)] MULTIDRUG [A]*ABUSE PROGRAM*.—[STUDY]

[(1)] The Secretary*, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations,* shall *provide, consistent with section 701, programs and services to prevent and treat* [conduct a study to determine the incidence and prevalence of] the abuse of multiple forms of *substances* [drugs], including, *but not limited to,* alcohol, *drugs, inhalants, and tobacco,* among Indian youths residing *in Indian communities, on or near* [Indian] reservations, and in urban areas and *provide appropriate mental health services to address* [the interrelationship of such abuse with] the incidence of mental illness among such youths.

[(2) The Secretary shall submit a report detailing the findings of such study, together with recommendations based on such findings, to the Congress no later than two years after October 29, 1992.]

§ 708. Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing

Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

§ 1665d. Training and [c]*Community* [e]*Education*

(a) *PROGRAM*.—[COMMUNITY EDUCATION]

The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement *or provide funding for Indian Tribes and Tribal Organizations to develop and implement,* within each [s]*S*ervice [u]*U*nit *or tribal program,* a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education *about behavioral health issues* [in alcohol and substance abuse] to political leaders, [t]*T*ribal judges, law enforcement personnel, members of tribal health and education boards, *health care providers including traditional practitioners,* and other critical members of each tribal community. *Community-based training (oriented toward local capacity development) shall also include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment, and aftercare.)*

(b) *INSTRUCTION*.—[TRAINING]

The Secretary*, acting through the Service,* shall, either directly or *through Indian Tribes and Tribal Organizations* [by contract], provide instruction in the area of *behavioral health issues* [alcohol and substance abuse], including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, *child sexual abuse,* youth alcohol and substance abuse, and the causes and effects of fetal alcohol *disorders* [syndrome] to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section *4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433)* [2433 of this title].

(c) *TRAINING* [COMMUNITY-BASED TRAINING M]*M*ODELS.—

In carrying out the education and training programs required by this section, the Secretary, [acting through the Service and] in consultation with *Indian T*[t]ribes, *Tribal Organizations, Indian behavioral health experts,* and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

(1) the elevated risk of alcohol and *behavioral health problems* [substance abuse] faced by children of alcoholics;

(2) the cultural, *spiritual,* and multigenerational aspects of *behavioral health problem* [alcohol and substance abuse] prevention and recovery; and

(3) community-based and multidisciplinary strategies for preventing and treating *behavioral health problems* [alcohol and substance abuse].

§ 710. Behavioral Health Program

(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

(b) FUNDING; CRITERIA.—The Secretary may award such funding for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

(1) The project will address significant unmet behavioral health needs among Indians.

(2) The project will serve a significant number of Indians.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

(5) The project may deliver services in a manner consistent with Traditional Health Care Practices.

(6) The project is coordinated with, and avoids duplication of, existing services.

(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any Funding Agreement, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

[§ 1665e. Gallup alcohol and substance abuse treatment center

[(a) GRANTS FOR RESIDENTIAL TREATMENT

[The Secretary shall make grants to the Navajo Nation for the purpose of providing residential treatment for alcohol and substance abuse for adult and adolescent members of the Navajo Nation and neighboring tribes.

[(b) PURPOSES OF GRANTS

[Grants made pursuant to this section shall (to the extent appropriations are made available) be used to—

[(1) provide at least 15 residential beds each year for adult long-term treatment, including beds for specialized services such as polydrug abusers, dual diagnosis, and specialized services for women with fetal alcohol syndrome children;

[(2) establish clinical assessment teams consisting of a clinical psychologist, a part-time addictionologist, a master's level assessment counselor, and a certified medical records technician which shall be responsible for conducting individual assessments and matching Indian clients with the appropriate available treatment;

[(3) provide at least 12 beds for an adolescent shelterbed program in the city of Gallup, New Mexico, which shall serve as a satellite facility to the Acoma/Canoncito/Laguna Hospital and the adolescent center located in Shiprock, New Mexico, for emergency crisis services, assessment, and family intervention;

[(4) develop a relapse program for the purposes of identifying sources of job training and job opportunity in the Gallup area and providing vocational training, job placement, and job retention services to recovering substance abusers; and

[(5) provide continuing education and training of treatment staff in the areas of intensive outpatient services, development of family support systems, and case management in cooperation with regional colleges, community colleges, and universities.

[(c) CONTRACT FOR RESIDENTIAL TREATMENT

[The Navajo Nation, in carrying out the purposes of this section, shall enter into a contract with an institution in the Gallup, New Mexico area which is accredited by the Joint Commission of the Accreditation of Health Care Organizations to provide comprehensive alcohol and drug treatment as authorized in subsection (b) of this section.

[(d) AUTHORIZATION OF APPROPRIATIONS

[There are authorized to be appropriated, for each of fiscal years 1996 through 2000, such sums as may be necessary to carry out subsection (b) of this section.

[§ 1665f. Reports

[(a) COMPILATION OF DATA

[The Secretary, with respect to the administration of any health program by a service unit, directly or through contract, including a contract under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], shall require the compilation of data relating to the number of cases or incidents in which any Service personnel or services were involved and which were related, either directly or

indirectly, to alcohol or substance abuse. Such report shall include the type of assistance provided and the disposition of these cases.

[(b) REFERRAL OF DATA

[The data compiled under subsection (a) of this section shall be provided annually to the affected Indian tribe and Tribal Coordinating Committee to assist them in developing or modifying a Tribal Action Plan under section 2412 of this title.

[(c) COMPREHENSIVE REPORT

[Each service unit director shall be responsible for assembling the data compiled under this section and section 2434 of this title into an annual tribal comprehensive report. Such report shall be provided to the affected tribe and to the Director of the Service who shall develop and publish a biennial national report based on such tribal comprehensive reports.]

§ 1665g. Fetal [a]*Alcohol* [d]*D*isorder [f]*F*unding.—syndrome and fetal alcohol effect grants]

(a) *PROGRAMS*.—[AWARD; USE; REVIEW CRITERIA]

(1) *ESTABLISHMENT*.—The Secretary*, consistent with section 701, acting through the Service, Indian Tribes, and Tribal Organizations, shall* [may make grants to Indian tribes and tribal organizations to] establish *and operate* fetal alcohol *disorder* [syndrome and fetal alcohol effect] programs as provided in this section for the purposes of meeting the health status objectives specified in section *3*[1602(b) of this title].

(2) *USE OF FUNDS*.—*Funding provided* [Grants made] pursuant to this section shall be used *for the following:*[to—]

(A) *To* develop and provide *for Indians* community and in[-]school training, education, and prevention programs relating to *fetal alcohol disorders.* [FAS and FAE;]

(B) *To* identify and provide *behavioral health* [alcohol and substance abuse] treatment to high-risk *Indian* women *and high-risk women pregnant with an Indian's child.*[;]

(C) *To* identify and provide appropriate *psychological services,* educational and vocational support, counseling, advocacy, and information to *fetal alcohol disorder* [FAS and FAE] affected *Indians* [persons] and their families or caretakers[;].

(D) *To* develop and implement counseling and support programs in schools for fetal alcohol disorder [FAS and FAE] affected *Indian* children[;].

(E) *To* develop prevention and intervention models which incorporate *practitioners of T*[t]raditional *Health Care Practices* [healers], cultural *and spiritual* values, and community involvement[;].

(F) *To* develop, print, and disseminate education and prevention materials on *fetal alcohol disorder.* [FAS and FAE; and]

(G) *To* develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools *including dysmorphology* clinics *and multidisciplinary fetal alcohol and disorder clinics* for use in [tribal and urban] Indian communities *and Urban Centers.*

(H) To develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorder among Indians.

(I) To develop and fund community-based adult fetal alcohol disorder housing and support services for Indians and for women pregnant with an Indian's child.

(3) *CRITERIA FOR APPLICATIONS*.—The Secretary shall establish criteria for the review and approval of applications for *funding* [grants] under this section.

(b) *SERVICES*.—[PLAN; STUDY; NATIONAL CLEARINGHOUSE]

The Secretary, acting through the Service and *Indian Tribes, Tribal Organizations, and Urban Indian Organizations,* shall—

(1) develop *and provide services* [an annual plan] for the prevention, intervention, treatment, and aftercare for those affected by *fetal alcohol disorder* [FAS and FAE] in Indian communities; *and*

(2) *provide supportive services, directly or through an Indian Tribe, Tribal Organization, or Urban Indian Organization, including services to meet* [conduct a study, directly or by contract with any organization, entity, or institution of higher education with significant knowledge of FAS and FAE and Indian communities, of] the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians *with fetal alcohol disorder.* [and Alaska Natives with FAS or FAE; and

[(3) establish a national clearinghouse for prevention and educational materials and other information of FAS and FAE effect in Indian and Alaska Native communities and ensure access to clearinghouse materials by any Indian tribe or urban Indian organization.]

(c) TASK [F]*F*ORCE.—

The Secretary shall establish a task force to be known as the *Fetal Alcohol Disorder* [FAS/FAE] Task Force to advise the Secretary in carrying out subsection (b) [of this section]. Such task force shall be composed of representatives from the *following:*

(1) The National Institute on Drug Abuse.[,]

(2) T[t]he National Institute on Alcohol and Alcoholism.[,]

(3) T[t]he Office of Substance Abuse Prevention.[,]

(4) T[t]he National Institute of Mental Health.[,]

(5) T[t]he Service.[,]

(6) T[t]he Office of Minority Health of the Department of Health and Human Services.[,]

(7) T[t]]he Administration for Native Americans.[,]

(8) The National Institute of Child Health and Human Development (NICHD).

(9) The Centers for Disease Control and Prevention.

(10) T[t]he Bureau of Indian Affairs.[,]

(11) Indian T[t]ribes.[,]

(12) T[t]ribal *O*[o]rganizations.[,]

(13) U[u]rban Indian *Organizations.* [communities, and]

(14) Indian fetal alcohol disorder [FAS/FAE] experts.

(d) [COOPERATIVE PROJECTS;] *APPLIED R*[R]ESEARCH *P*[P]ROJECTS.—

The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make *funding available*

[grants] to Indian *T*[t]ribes, *T*[t]ribal *O*[o]rganizations, *and Urban Indian Organizations* [universities working with Indian tribes on cooperative projects, and urban Indian organizations] for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide *rehabilitation and behavioral health* aftercare for Indians and *U*[u]rban Indians affected by *fetal alcohol disorder* [FAS or FAE].

[(e) REPORT

[(1) The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the status of FAS and FAE in the Indian population. Such report shall include, in addition to the information required under section 1602(d) of this title with respect to the health status objective specified in section 1602(b)(27) of this title, the following:

[(A) The progress of implementing a uniform assessment and diagnostic methodology in Service and tribally based service delivery systems.

[(B) The incidence of FAS and FAE babies born for all births by reservation and urban-based sites.

[(C) The prevalence of FAS and FAE affected Indian persons in Indian communities, their primary means of support, and recommendations to improve the support system for these individuals and their families or caretakers.

[(D) The level of support received from the entities specified in subsection (c) of this section in the area of FAS and FAE.

[(E) The number of inpatient and outpatient substance abuse treatment resources which are specifically designed to meet the unique needs of Indian women, and the volume of care provided to Indian women through these means.

[(F) Recommendations regarding the prevention, intervention, and appropriate vocational, educational and other support services for FAS and FAE affected individuals in Indian communities.

[(2) The Secretary may contract the production of this report to a national organization specifically addressing FAS and FAE in Indian communities.

[(f) AUTHORIZATION OF APPROPRIATIONS

[(1) There are authorized to be appropriated to carry out this section $22,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.]

(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—[(2)] Ten percent of the funds appropriated pursuant to this section shall be used to make grants to *U*[u]rban Indian *O*[o]rganizations funded under *title V* [subchapter IV of this chapter].

[§ 1665h. Pueblo substance abuse treatment project for San Juan Pueblo, New Mexico

[The Secretary, acting through the Service, shall continue to make grants, through fiscal year 1995, to the 8 Northern Indian Pueblos Council, San Juan Pueblo, New Mexico, for the purpose of

providing substance abuse treatment services to Indians in need of such services.

[§ 1665i. Thunder Child Treatment Center

[(a) The Secretary, acting through the Service, shall make a grant to the Intertribal Addictions Recovery Organization, Inc. (commonly known as the Thunder Child Treatment Center) at Sheridan, Wyoming, for the completion of construction of a multiple approach substance abuse treatment center which specializes in the treatment of alcohol and drug abuse of Indians.

[(b) For the purposes of carrying out subsection (a) of this section, there are authorized to be appropriated $2,000,000 for fiscal years 1993 and 1994. No funding shall be available for staffing or operation of this facility. None of the funding appropriated to carry out subsection (a) of this section shall be used for administrative purposes.

[§ 1665j. Substance abuse counselor education demonstration project

[(a) CONTRACTS AND GRANTS

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

[(b) USE OF FUNDS

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

[(c) EFFECTIVE PERIOD OF CONTRACT OR GRANT; RENEWAL

[A contract entered into or a grant provided under this section shall be for a period of one year. Such contract or grant may be renewed for an additional one year period upon the approval of the Secretary.

[(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS

[Not later than 180 days after October 29, 1992, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to education substance abuse counselors.

[(e) ASSISTANCE TO RECIPIENTS

[The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

[(f) REPORT

[The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions

derived from the demonstration projects conducted under this section.]

§ 712. Child Sexual Abuse and Prevention Treatment Programs

(a) ESTABLISHMENT.—The Secretary, acting through the Service, and the Secretary of the Interior, Indian Tribes, and Tribal Organizations shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

(1) victims of sexual abuse who are Indian children or children in an Indian household; and

(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

(3) To develop prevention and intervention models which incorporate Traditional Health Care Practices, cultural and spiritual values, and community involvement.

(4) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and

(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

§ 713. Behavioral Health Research

The Secretary, 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 interrelationship and interdependence 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.

The effect of the interrelationships and interdependencies referred to in paragraph (1) on children, and the development of prevention

techniques under paragraph (2) applicable to children, shall be emphasized.

§ *714.* [(g)] Definitions

For the purposes of this *title* [section], the following definitions *shall* apply:

(1) *ASSESSMENT.—The term 'assessment' means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.* [The term "educational curriculum" means one or more of the following:

[(A) Classroom education.

[(B) Clinical work experience.

[(C) Continuing education workshops.]

(2) *ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term 'alcohol-related neurodevelopmental disorders' or 'ARND' means a central nervous system or behavioral disorder, following a maternal history of alcohol consumption during pregnancy, that may involve—*

(A) physical manifestations such as development delay, intellectual deficit, neurologic abnormalities, or failure to thrive as infants; or

(B) behavioral manifestations such as irritability, or for older children, hyperactivity, attention deficit, language dysfunction, or perceptual or judgment difficulties.

The term "eligible community college" means an accredited community college that—

[(i) is located on or near an Indian reservation;

[(ii) has entered into a cooperative agreement with the governing body of such Indian reservation to carry out a demonstration project under this section; and

[(iii) has a student enrollment of not less than 10 percent Indian.]

(3) BEHAVIORAL HEALTH AFTERCARE.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers (mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, ministers, etc.)

[(3) The term "tribally controlled community college" has the meaning given such term in section 1801(a)(4) of this title.]

(4) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

[(4) The term "tribally controlled postsecondary vocational institution" has the meaning given such term in section 2397h(2) of Title 20.]

(5) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome and alcohol related neurodevelopmental disorder (ARND).

(6) FETAL ALCOHOL SYNDROME OR FAS.—The term 'fetal alcohol syndrome' or 'FAS' means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

(C) Prenatal or postnatal growth delay.

(7) PARTIAL FAS.—The term 'partial FAS' means, with a history of maternal alcohol consumption during pregnancy, having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

(8) REHABILITATION. The term 'rehabilitation' means to restore the ability or capacity to engage in usual and customary life activities through education and therapy.

(9) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

§ *715.* [(h)] Authorization of *A*[a]ppropriations

There *is* [are] authorized to be appropriated [for each of fiscal years 1996 through 2000,] such sums as may be necessary *for each fiscal year through fiscal year 2015* to carry out the *provisions* [purposes] of this *title* [section]. [Such sums shall remain available until expended.]

[§ 1665k. Gila River alcohol and substance abuse treatment facility

[(a) REGIONAL CENTER

[The Secretary, acting through the Service, shall establish a regional youth alcohol and substance abuse prevention and treatment center in Sacaton, Arizona, on the Gila River Indian Reservation. The center shall be established within facilities leased, with the consent of the Gila River Indian Community, by the Service from such Community.

[(b) NAME OF REGIONAL CENTER

[The center established pursuant to this section shall be known as the "Regional Youth Alcohol and Substance Abuse Prevention and Treatment Center".

[(c) UNIT OF REGIONAL CENTER

[The Secretary, acting through the Service, shall establish, as a unit of the regional center, a youth alcohol and substance abuse prevention and treatment facility in Fallon, Nevada.

[§ 1665*l*. Alaska Native drug and alcohol abuse demonstration project

[(a) The Secretary, acting through the Service, shall make grants to the Alaska Native Health Board for the conduct of a two-part community-based demonstration project to reduce drug and alcohol abuse in Alaska Native villages and to rehabilitate families afflicted by such abuse. Sixty percent of such grant funds shall be used by the Health Board to stimulate coordinated community development programs in villages seeking to organize to combat alcohol and drug use. Forty percent of such grant funds shall be transferred to a qualified nonprofit corporation providing alcohol recovery services in the village of St. Mary's, Alaska, to enlarge and strengthen a family life demonstration program of rehabilitation for families that have been or are afflicted by alcoholism.

[(b) The Secretary shall submit to the President for inclusion in the report required to be submitted to the Congress under section 1671 of this title for fiscal year 1995 an evaluation of the demonstration project established under subsection (a) of this section.

[§ 1665m. Authorization of appropriations

[Except as provided in sections 1665b, 1665e, 1665g, 1665i, and 1665j of this title, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out the provisions of this subchapter.]

TITLE VIII [SUBCHAPTER VI]—MISCELLANEOUS

§ 1671. Reports

The President shall, at the time the budget is submitted under section 1105 of [T]*t*itle 31, *United States Code,* for each fiscal year transmit to [the] Congress a report containing *the following:*[—]

(1) *A*[a] report on the progress made in meeting the objectives of this *Act*[chapter], including a review of programs established or assisted pursuant to this *Act*[chapter] and [an] assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians[,] and ensure a health status for Indians, which are at a parity with the health services available to and the health status of[,] the general population, *including specific comparisons of appropriations provided and those required for such parity.*[;]

(2) *A*[a] report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this *Act*[chapter] and any steps that the Secretary may have taken to consult with Indian [t]*T*ribes, *Tribal Organizations, and Urban Indian Organizations* to address such impact, *including a report on proposed changes in allocation of funding pursuant to section 808.*[;]

(3) *A*[a] report on the use of health services by Indians—

(A) on a national and area or other relevant geographical basis;

(B) by gender and age;

(C) by source of payment and type of service; [and]

(D) comparing such rates of use with rates of use among comparable non-Indian populations[.]*; and*

(E) provided under Funding Agreements.

(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(n).

(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 126(f).

(7)[(4) a]*A* separate statement which specifies the amount of funds requested to carry out the provisions of section *201.* [1621 of this title;]

(8) A report of the evaluations of health promotion and disease prevention as required in section 203(c).

(9) A biennial report to Congress on infectious diseases as required by section 212.

(10) A report on environmental and nuclear health hazards as required by section 215.

(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2) and 301(d).

(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

(13) An annual report on the expenditure of nonservice funds for renovation as required by sections 304(b)(2).

(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

(16) A report on any arrangements for the sharing of medical facilities or services between the Service, Indian Tribes, and Tribal Organizations, and the Department of Veterans Affairs and the Department of Defense, as authorized by section 406.

(17) A report on evaluation and renewal of Urban Indian programs under section 505.

(18) A report on the evaluation of programs as required by section 513(d).

(19) A report on alcohol and substance abuse as required by section 701(f).

[(5) a separate statement of the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in section 1680d of this title, relating to infant and maternal mortality and fetal alcohol syndrome;

[(6) the reports required by the sections 1602(d), 1616a(n), 1621b(b), 1621h(j), 1631(c), 1632(g), 1634(a)(3), 1643, 1665g(e), and 1680g(a), and 1680l(f) of this title;

[(7) for fiscal year 1995, the report required by sections 1665a(c)(3) and 1665l(b) of this title;

[(8) for fiscal year 1997, the interim report required by section 1637(h)(1) of this title; and

[(9) for fiscal year 1999, the reports required by sections 1637(h)(2), 1660b(b), 1665j(f), and 1680k(g) of this title.]

§ 1672. Regulations

(a) DEADLINES.—

(1) PROCEDURES.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out titles I, II, III, and VII and section 817. The Secretary may promulgate regulations to carry out sections 105, 115, 117, and titles IV and V, using the procedures required by chapter V of title 5, United States Code (commonly known as the 'Administrative Procedure Act'. The Secretary shall issue no regulations to carry out titles VI and VIII, except as necessary to carry out section 817.

(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 270 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004 and shall have no less than a 120-day comment period.

(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of the enactment of this Act.

(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United 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) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law in effect on the day before the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

[Prior to any revision of or amendment to rules or regulations promulgated pursuant to this chapter, the Secretary shall consult with Indian tribes and appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

[§ 1673. Repealed.

[§ 1674. Leases with Indian tribes

[(a) Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this chapter, to enter into leases with Indian tribes for periods not in excess of twenty years. Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.

[(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

[(1) title to;

[(2) a leasehold interest in; or

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

[facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable.]

§ 803. Plan of Implementation

Not later than 8 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, the Secretary in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule (including a schedule of appropriation requests), by title and section, by which the Secretary will implement the provisions of this Act.

§ 1675. Availability of *F*[f]unds

The funds appropriated pursuant to this *Act* [chapter] shall remain available until expended.

§ 1676. Limitation on *U*[u]se of *F*[f]unds *A*[a]ppropriated to the Indian Health Service

Any limitation on the use of funds contained in an Act providing appropriations for the Department [of Health and Human Services] for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the [Indian Health] Service.

[§ 1677. Nuclear resource development health hazards

[(a) STUDY

[The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, a study of the health hazards to Indian miners and Indians on or near Indian reservations and in Indian communities as a result of nuclear resource development. Such study shall include—

[(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

[(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

[(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal;

[(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the five years prior to December 17, 1980, that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

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

[(b) HEALTH CARE PLAN; DEVELOPMENT

[Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studied under subsection (a) of this section. The plan shall include—

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

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

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

[(c) REPORTS TO CONGRESS

[The Secretary and the Service shall submit to Congress the study prepared under subsection (a) of this section no later than the date eighteen months after December 17, 1980. The health care plan prepared under subsection (b) of this section shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) of this section is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

[(d) INTERGOVERNMENTAL TASK FORCE; ESTABLISHMENT AND FUNCTIONS

[(1) There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees): the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the United States

Bureau of Mines, the Assistant Secretary for Occupational Safety and Health, and the Secretary of the Interior.

[(2) The Task Force shall identify existing and potential operations related to nuclear resource development that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community and enter into activities to correct existing health hazards and insure that current and future health problems resulting from nuclear resource development activities are minimized or reduced.

[(3) The Secretary shall be Chairman of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

[(e) MEDICAL CARE

[In the case of any Indian who—

[(1) as a result of employment in or near a uranium mine or mill, suffers from a work related illness or condition;

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

[(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator;

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

[§ 1678. Arizona as a contract health service delivery area

[(a) DESIGNATION

[For the fiscal years beginning with the fiscal year ending September 30, 1982, and ending with the fiscal year ending September 30, 2000, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian tribes of Arizona.

[(b) CURTAILMENT OF HEALTH SERVICES PROHIBITED

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

§ 1679. Eligibility of California Indians

(a) *IN GENERAL.*—[REPORT TO CONGRESS]

The following California Indians shall be eligible for health services provided by the Service:

[(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth—

[(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,

[(B) the geographic location of such Indians,

[(C) the Indian tribes of which such Indians are members,

[(D) an assessment of the current health status, and health care needs, of such Indians, and

[(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

[(2) The report required under paragraph (1) shall be prepared by the Secretary—

[(A) in consultation with the Secretary of the Interior, and

[(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.

[(b) ELIGIBLE INDIANS

[Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:]

(1) Any member of a federally recognized Indian *T*[t]ribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, [but only] if such descendant—

[(A) is living in California,]

(A)[(B)] is a member of the Indian community served by a local program of the Service[,]*;* and

(B)[(C)] is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or [Indian] reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of [California] rancherias and reservations *located within the State of California* under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(b)[(c)] *CLARIFICATION.*—[SCOPE OF ELIGIBILITY]

Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§ 1680. California as a contract health service delivery area

[The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Sant Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health

service delivery area by the Service for the purpose of providing contract health services to Indians in such State.

[§ 1680a. Contract health facilities

[The Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Service entered into under the Indian Self-Determination Act [25 U.S.C.A § 450f et seq.]—

[(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,

[(2) for employee training,

[(3) for cost-of-living increases for employees, and

[(4) for any other expenses relating to the provision of health services,

[on the same basis as such funds are provided to programs and facilities operated directly by the Service.

[§ 1680b. National Health Service Corps

[The Secretary of Health and Human Services shall not—

[(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.], or

[(2) withdraw funding used to support such member,

[unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.]

§ 1680c. Health *S*[s]ervices for *I*[i]neligible *P*[p]ersons

(a) *CHILDREN.*—[*INDIVIDUALS NOT OTHERWISE ELIGIBLE*]

[(1)] Any individual who—

(*1*)[(A)] has not attained 19 years of age[,]*;*

(*2*)[(B)] is the natural or adopted child, step[-]child, foster[-]child, legal ward, or orphan of an eligible Indian[,]*;* and

(*3*)[(C)] is not otherwise eligible for the health services provided by the Service, shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until *1*[one] year after the date *of a determination of competency* [such disability has been removed].

(b) *SPOUSES.*—[(2)] Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but 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(s) 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* [of the eligible Indian]. The health needs of persons made eligible

under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(c)[(b)] *PROVISION OF SERVICES TO OTHER INDIVIDUALS.*—[HEALTH FACILITIES PROVIDING HEALTH SERVICE]

(1)[(A)] *IN GENERAL.*—The Secretary is authorized to provide health services under this subsection through health *programs* [facilities] operated directly by the Service to individuals who reside within the [service area of a s]*S*ervice [u]*U*nit and who are not *otherwise* eligible for such health services [under any other subsection of this section or under any other provision of law] if—

(A)[(i)] the Indian *T*[t]ribes [(or, in the case of a multi-tribal service are, all the Indian tribes)] served by such [s]*S*ervice [u]*U*nit request[s] such provision of health services to such individuals[,]*;* and

(B)[(ii)] the Secretary and the *served* Indian [tribe or t]*T*ribes have jointly determined that—

(i)[(I)] the provision of such health services will not result in a denial or diminution of health services to eligible Indians[,]*;* and

(ii)[(II)] there is no reasonable alternative health facilit[y]*ies* or services, within or without the [service area of such [s]*S*ervice [u]*U*nit, available to meet the health needs of such individuals.

(2)[(B)] *ISDEAA PROGRAMS.*—In the case of *a Tribal Health Program* [health facilities operated under a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]], the governing body of the Indian [t]*T*ribe or *T*[t]ribal *O*[o]rganization providing health services under such *Tribal Health Program* [contract] is authorized to determine whether health services should be provided under *its Funding Agreement* [such contract] to individuals who are not *otherwise* eligible for such [health] services [under any other subsection of this section or under any other provision of law]. In making such determination[s], the governing body [of the Indian tribe or tribal organization] shall take into account the considerations described in *clauses (i) and (ii) of paragraph (1)(B)* [subparagraph (A)(ii)].

(3)[(2)] *PAYMENT FOR SERVICES.*—

(A) *IN GENERAL.*—Persons receiving health services provided by the Service *under* [by reason of] this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section *404*[1880(c)] of *this* [the Social Security] Act [[42 U.S.C.A. § 1395qq(c)], section 1642(a) of this title,] or any other provision of law, amounts collected under this subsection, including medicare, [or] medicaid or *SCHIP* reimbursements under titles XVIII, [and] XIX, *and XXI* of the Social Security Act [[42 U.S.C.A. §§ 1395 et seq., 1396 et seq.]], shall be credited to the account of the *program* [facility] providing the service and shall be used [solely] for the *purposes listed in sec-*

tion 401(d)(2) and [provision of health services within that facility. A]*a*mounts collected under this subsection shall be available for expenditure within such *program* [facility for not to exceed one fiscal year after the fiscal year in which collected].

(B) *INDIGENT PEOPLE.*—Health services may be provided by the Secretary through the Service under this subsection to an indigent *individual* [person] who would not be *otherwise* eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent *individual* [person].

(4)[(3)] *REVOCATION OF CONSENT FOR SERVICES.*—

(A) *SINGLE TRIBE SERVICE AREA.*—In the case of a *S*[s]ervice *A*[a]rea which serves only *1*[one] Indian *T*[t]ribe, the authority of the Secretary to provide health services under paragraph (1)[(A)] shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian *T*[t]ribe revokes its concurrence to the provision of such health services.

(B) *MULTITRIBAL SERVICE AREA.*—In the case of a multi[-]tribal *S*[s]ervice *A*[a]rea, the authority of the Secretary to provide health services under paragraph (1)[(A)] shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian *T*[t]ribes in the *S*[s]ervice *A*[a]rea revoke their concurrence to the provision of such health services.

(d)[(c)] *OTHER SERVICES.*—[PURPOSES SERVED IN PROVIDING HEALTH SERVICES TO OTHERWISE INELIGIBLE INDIVIDUALS]

The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other [subsection of this section or under any other] provision of law in order to—

(1) achieve stability in a medical emergency[,]*;*

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard[,]*;*

(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post[ ]partum[,]*;* or

(4) provide care to immediate family members of an eligible *individual* [person] if such care is directly related to the treatment of the eligible *individual* [person].

(e)[(d) EXTENSION OF H]*H*OSPITAL [P]*P*RIVILEGES FOR [TO NON-SERVICE HEALTH CARE p]*P*RACTITIONERS

Hospital privileges in health facilities operated and maintained by the Service or operated under a *Funding Agreement* [contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.]] may be extended to non-Service health care practitioners who provide services to *individuals* [persons] described in subsection (a), [or] (b)*, (c), or (d)* [of this section]. Such non-Service health care practitioners may*, as part of the privileging process,* be *designated* [regarded] as employees of the Federal Government

for purposes of section 1346(b) and chapter 171 of Title 28, *United States Code* (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible *individuals* [persons] as a part of the conditions under which such hospital privileges are extended.

(*f*)[(e) "]ELIGIBLE INDIAN[" DEFINED].—

For purposes of this section, the term ["]*'eligible Indian'*["] means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

[§ 1680d. Infant and maternal mortality; fetal alcohol syndrome

[By no later than January 1, 1990, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1994:

[(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—

[(A) twelve deaths per one thousand live births, or

[(B) the rate of infant mortality applicable to the United States population as a whole;

[(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—

[(A) five deaths per one hundred thousand live births, or

[(B) the rate of maternal mortality applicable to the United States population as a whole; and

[(3) reduction of the rate of fetal alcohol syndrome among Indians served by, or on behalf of, the Service to one per one thousand births.

[§ 1680e. Contract health services for the Trenton Service Area

[(a) SERVICE TO TURTLE MOUNTAIN BAND

[The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

[(b) BAND MEMBER ELIGIBILITY NOT EXPANDED

[Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

[§ 1680f. Indian Health Service and Department of Veterans Affairs health facilities and services sharing

[(a) FEASIBILITY STUDY AND REPORT

[The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Department of Veterans Affairs and shall, in accordance with subsection (b) of this section, prepare a report on the feasibility of such an arrangement and submit such report to the Congress by no later than September 30, 1990.

[(b) NONIMPAIRMENT OF SERVICE QUALITY, ELIGIBILITY, OR PRIORITY OF ACCESS

[The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of Title 38 which would impair—

[(1) the priority access of any Indian to health care services provided through the Indian Health Service;

[(2) the quality of health care services provided to any Indian through the Indian Health Service;

[(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

[(4) the quality of health care services provided to any veteran by the Department of Veterans Affairs;

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

[(6) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

[(c) CROSS UTILIZATION OF SERVICES

[(1) Not later than December 23, 1988, the Director of the Indian Health Service and the Secretary of Veterans Affairs shall implement an agreement under which—

[(A) individuals in the vicinity of Roosevelt, Utah, who are eligible for health care from the Department of Veterans Affairs could obtain health care services at the facilities of the Indian Health Service located at Fort Duchesne, Utah; and

[(B) individuals eligible for health care from the Indian Health Service at Fort Duchesne, Utah, could obtain health care services at the George E. Wahlen Department of Veterans Affairs Medical Center located in Salt Lake City, Utah.

[(2) Not later than November 23, 1990, the Secretary and the Secretary of Veterans Affairs shall jointly submit a report to the Congress on the health care services provided as a result of paragraph (1).

[(d) RIGHT TO HEALTH SERVICES

[Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Indian Health Service except as provided in an agreement under subsection (c) of this section.]

§ 1680g. Reallocation of *B*[b]ase *R*[r]esources

(a) REPORT *REQUIRED*.—[TO CONGRESS]

Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a *S*[s]ervice *U*[u]nit may be implemented only after the Secretary has submitted to the President, for inclusion in the report required to be transmitted to [the] Congress under section *801*[1671 of this title], a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

(b) *EXCEPTION*.—[APPROPRIATED AMOUNTS]

Subsection (a) [of this section] shall not apply if the total amount appropriated to the Service for a fiscal year is *at least 5*

percent less than the amount appropriated to the Service for *the* previous fiscal year.

[§ 1680h. Demonstration projects for tribal management of health care services

[(a) ESTABLISHMENT; GRANTS

[(1) The Secretary, acting through the Service, shall make grants to Indian tribes to establish demonstration projects under which the Indian tribe will develop and test a phased approach to assumption by the Indian tribe of the health care delivery system of the Service for members of the Indian tribe living on or near the reservations of the Indian tribe through the use of Service, tribal, and private sector resources.

[(2) A grant may be awarded to an Indian tribe under paragraph (1) only if the Secretary determines that the Indian tribe has the administrative and financial capabilities necessary to conduct a demonstration project described in paragraph (1).

[(b) HEALTH CARE CONTRACTS

[During the period in which a demonstration project established under subsection (a) of this section is being conducted by an Indian tribe, the Secretary shall award all health care contracts, including community, behavioral, and preventive health care contracts, to the Indian tribe in the form of a single grant to which the regulations prescribed under part A of title XIX of the Public Health Service Act [42 U.S.C.A. § 300w et seq. (as modified as necessary by any agreement entered into between the Secretary and the Indian tribe to achieve the purposes of the demonstration project established under subsection (a) of this section) shall apply.

[(c) WAIVER OF PROCUREMENT LAWS

[The Secretary may waive such provisions of Federal procurement law as are necessary to enable any Indian tribe to develop and test administrative systems under the demonstration project established under subsection (a) of this section, but only if such waiver does not diminish or endanger the delivery of health care services to Indians.

[(d) TERMINATION; EVALUATION AND REPORT

[(1) The demonstration project established under subsection (a) of this section shall terminate on September 30, 1993, or, in the case of a demonstration project for which a grant is made after September 30, 1990, three years after the date on which such grant is made.

[(2) By no later than September 30, 1996, the Secretary shall evaluate the performance of each Indian tribe that has participated in a demonstration project established under subsection (a) of this section and shall submit to the Congress a report on such evaluations and demonstration projects.

[(e) JOINT VENTURE DEMONSTRATION PROJECTS

[(1) The Secretary, acting through the Service, shall make arrangements with Indian tribes to establish joint venture demonstrative projects under which an Indian tribe shall expend tribal, private, or other available nontribal funds, for the acquisition or construction of a health facility for a minimum of 20 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. A tribe

may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

[(2) The Secretary shall make such an arrangement with an Indian tribe only if the Secretary first determines that the Indian tribe has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in paragraph (1).

[(3) An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this subsection, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe, or paid to a third party on the tribe's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, or for personnel or staffing, shall be recoverable.

[§ 1680i. Child sexual abuse treatment programs

[(a) CONTINUATION OF EXISTING DEMONSTRATION PROGRAMS

[The Secretary and the Secretary of the Interior shall, for each fiscal year through fiscal year 1995, continue the demonstration programs involving treatment for child sexual abuse provided through the Hopi Tribe and the Assiniboine and Sioux Tribes of the Fort Peck Reservation.

[(b) ESTABLISHMENT OF NEW DEMONSTRATION PROGRAMS

[Beginning October 1, 1995, the Secretary and the Secretary of the Interior may establish, in any service area, demonstration programs involving treatment for child sexual abuse, except that the Secretaries may not establish a greater number of such programs in one service area than in any other service area until there is an equal number of such programs established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).

[§ 1680j. Tribal leasing

[Indian tribes providing health care services pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

[§ 1680k. Home- and community-based care demonstration project

[(a) AUTHORITY OF SECRETARY

[The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations providing health care services pursuant to a contract entered into under the Indian Self-Determination Act [25 U.S.C.A. §450f et seq.], to establish demonstration projects for the delivery

of home- and community-based services to functionally disabled Indians.

[(b) USE OF FUNDS

[(1) Funds provided for a demonstration project under this section shall be used only for the delivery of home- and community-based services (including transportation services) to functionally disabled Indians.

[(2) Such funds may not by used—

[(A) to make cash payments to functionally disabled Indians;

[(B) to provide room and board for functionally disabled Indians;

[(C) for the construction or renovation of facilities or the purchase of medical equipment; or

[(D) for the provision of nursing facility services.

[(c) CRITERIA FOR APPROVAL OF APPLICATIONS

[Not later than 180 days after October 29, 1992, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and issue criteria for the approval of applications submitted under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of tribes and tribal organizations to deliver, or arrange for the delivery of, high quality, culturally appropriate home- and community-based services to functionally disabled Indians;

[(d) ASSISTANCE TO APPLICANTS

[The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

[(e) SERVICES TO INELIGIBLE PERSONS

[At the discretion of the tribe or tribal organization, services provided under a demonstration project established under this section may be provided (on a cost basis) to persons otherwise ineligible for the health care benefits of the Service.

[(f) MAXIMUM NUMBER OF DEMONSTRATION PROJECTS

[The Secretary shall establish not more than 24 demonstration projects under this section. The Secretary may not establish a greater number of demonstration projects under this section in one service area than in any other service area until there is an equal number of such demonstration projects established with respect to all service areas from which the Secretary receives applications during the application period (as determined by the Secretary) which meet the criteria issued pursuant to subsection (c) of this section.

[(g) REPORT

[The Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 1671 of this title for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section, together with legislative recommendations.

[(h) DEFINITIONS

[For the purposes of this section, the following definitions shall apply:

[(1) The term "home- and community-based services" means one or more of the following:

[(A) Homemaker/home health aide services.

[(B) Chore services.

[(C) Personal care services.

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

[(E) Respite care.

[(F) Training for family members in managing a functionally disabled individual.

[(G) Adult day care.

[(H) Such other home- and community-based services as the Secretary may approve.

[(2) The term "functionally disabled" means an individual who is determined to require home- and community-based services based on an assessment that uses criteria (including, at the discretion of the tribe or tribal organization, activities of daily living) developed by the tribe or tribal organization.

[(i) AUTHORIZATION OF APPROPRIATIONS

[There are authorized to be appropriated for each of the fiscal years 1996 through 2000 such sums as may be necessary to carry out this section. Such sums shall remain available until expended.

[§ 1680*l*. Shared services demonstration project

[(a) AUTHORITY OF SECRETARY

[The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into contracts with Indian tribes or tribal organizations to establish not more than 6 shared services demonstration projects for the delivery of long-term care to Indians. Such projects shall provide for the sharing of staff or other services between a Service facility and a nursing facility owned and operated (directly or by contract) by such Indian tribe or tribal organization.

[(b) CONTRACT REQUIREMENTS

[A contract entered into pursuant to subsection (a) of this section—

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

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

[(3) may authorize such tribe or tribal organization to construct, renovate, or expand a nursing facility (including the construction of a facility attached to a Service facility), except that no funds appropriated for the Service shall be obligated or expended for such purpose.

[(c) ELIGIBILITY

[To be eligible for a contract under this section, a tribe or tribal organization, shall, as of October 29, 1992—

[(1) own and operate (directly or by contract) a nursing facility;

[(2) have entered into an agreement with a consultant to develop a plan for meeting the long-term needs of the tribe or tribal organization; or

[(3) have adopted a tribal resolution providing for the construction of a nursing facility.

[(d) NURSING FACILITIES

[Any nursing facility for which a contract is entered into under this section shall meet the requirements for nursing facilities under section 1396r or Title 42.

[(e) ASSISTANCE TO APPLICANTS

[The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

[(f) REPORT

[The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 1671 of this title, a report on the findings and conclusions derived from the demonstration projects conducted under this section.]

§1680m. Results of [d]*D*emonstration [p]*P*rojects

The Secretary shall provide for the dissemination to Indian *T*[t]ribes, *Tribal Organizations, and Urban Indian Organizations* of the findings and results of demonstration projects conducted under this *Act* [chapter].

[§1680n. Priority for Indian reservations

[(a) FACILITIES AND PROJECTS

[Beginning on October 29, 1992, the Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian tribe with jurisdiction over such lands.

[(b) "INDIAN LANDS" DEFINED

[For purposes of this section, the term "Indian lands" means—

[(1) all lands within the limits of any Indian reservation; and

[(2) any lands title which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power.]

§ 810. Provision of Services in Montana

(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the

provision of services or benefits for Indians living in any State other than Montana.

[§ 1680o. Authorization of appropriations

[Except as provided in section 1680k of this title, there are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2000 to carry out this subchapter.**]**

§ 811. Moratorium.

During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration of the Public Health Service, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

[§ 1681. Omitted]

§ 812. Tribal Employment.

For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a Funding Agreement shall not be considered an 'employer'.

[§ 1682. Subrogation of claims by Indian Health Service

[On and after October 18, 1986, the Indian Health Service may seek subrogation of claims including but not limited to auto accident claims, including no-fault claims, personal injury, disease, or disability claims, and worker's compensation claims, the proceeds of which shall be credited to the funds established by sections 401 and 402 of the Indian Health Care Improvement Act.**]**

§ 813. Prime Vendor.

(a) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), a Tribal Health Program shall be deemed an executive agency when carrying out a contract, grant, cooperative agreement, or Funding Agreement with the Service and shall have access to the Federal Supply Schedule and any other Federal source of supply to which executive agencies have access.

(b) IHS STATUS.—For purposes of section 4 of Public Law 102–585 (38 U.S.C. 8126), a Tribal Health Program shall have the status of the Indian Health Service and shall have direct access to the Veterans Administration prime vendor provided for in section 4 of Public Law 102–585.

(c) EMPLOYEE STATUS.—The employees of such Tribal Health Programs may order supplies under such respective programs on the same basis as employees of the Service.

[§ 1683. Indian Catastrophic Health Emergency Fund

[$10,000,000 shall remain available until expended, for the establishment of an Indian Catastrophic Health Emergency Fund (hereinafter referred to as the "Fund"). On and after October 18, 1986, the Fund is to cover the Indian Health Service portion of the medical expenses of catastrophic illness falling within the responsibility of the Service and shall be administered by the Secretary of Health and Human Services, acting through the central office of the Indian Health Service. No part of the Fund or its administration shall be subject to contract or grant under the Indian Self-Determination and Education Assistance Act (Public Law 93–638) [25 U.S.C.A. § 450 et seq.]. There shall be deposited into the Fund all amounts recovered under the authority of the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), which shall become available for obligation upon receipt and which shall remain available for obligation until expended. The Fund shall not be used to pay for health services provided to eligible Indians to the extent that alternate Federal, State, local, or private insurance resources for payment: (1) are available and accessible to the beneficiary; or (2) would be available and accessible if the beneficiary were to apply for them; or (3) would be available and accessible to other citizens similarly situated under Federal, State, or local law or regulation or private insurance program notwithstanding Indian Health Service eligibility or residency on or off a Federal Indian reservation.**]**

§ 814. 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.

§ 815. Establishment of National Bipartisan Commission on Indian Health Care Entitlement.

(a) ESTABLISHMENT.—There is hereby established the National Bipartisan Indian Health Care Entitlement Commission (the 'Commission').

(b) DUTIES OF COMMISSION.—The duties of the Commission are the following:

(1) To establish a study committee composed of those members of the Commission appointed by the Director and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:

(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

(B) To make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which will address, among other things, 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 making funds available for the health services to be provided.

(C) To determine the effect of the enactment of such recommendations on (i) the existing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study committee in the course of carrying out its duties under this section.

(2) To review and analyze the recommendations of the report of the study committee.

(3) To make recommendations to Congress for providing health services for Indians as an entitlement, giving due regard to the effects of such a program on existing health care delivery systems for Indians and the effect of such a program on the sovereign status of Indian Tribes.

(4) Not later than 18 months following 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 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 on the sovereign status of Indian Tribes.

(c) MEMBERS.—

(1) APPOINTMENT.—The Commission shall be composed of 25 members, appointed as follows:

(A) Ten members of Congress, including 3 from the House of Representatives and 2 from the Senate, appointed by their respective majority leaders, and 3 from the House of Representatives and 2 from the Senate, appointed by their respective minority leaders, and who shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

(B) Twelve persons chosen by the congressional members of the Commission, 1 from each Service Area as currently designated by the Director to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of

health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

(D) All those persons chosen by the congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the congressional members of the Commission.

(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2004, and the remaining members of the Commission shall be appointed not later than 60 days following the appointment of the congressional members.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(d) COMPENSATION.—

(1) CONGRESSIONAL MEMBERS.—Each congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(2) OTHER MEMBERS.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(e) MEETINGS.—The Commission shall meet at the call of the Chair.

(f) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—

(1) APPOINTMENT; PAY.—The Commission shall appoint an executive director of the Commission. The executive director

shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF APPOINTMENT.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

(3) STAFF PAY.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) TEMPORARY SERVICES.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) FACILITIES.—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(h) HEARINGS.—

(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count toward the number of regional hearings required by this subsection.

(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commis-

sion as the Commission determines to be necessary to carry out its duties.

(6) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this section, which sum shall not be deducted from or affect any other appropriations for health care for Indian persons.

(j) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

§ 816. 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.

§ 817. Confidentiality of Medical Quality Assurance Records: Qualified Immunity for Participants

(a) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

(b) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

(1) No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).

(2) A person who reviews or creates medical quality assurance records for any Indian health program or Urban Indian Organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evalua-

tion, opinion, or action taken by such person or body in connection with such records except as provided in this section.

(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

(1) Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform monitoring, required by law, of such program or organization.

(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization.

(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

(E) To an officer, employee, or contractor of the Indian Health Program or Urban Indian Organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

(2) With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such

program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization. Such requirement does not apply to the release of information pursuant to section 552a of title 5.

(d) DISCLOSURE FOR CERTAIN PURPOSES.—

(1) Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organizations's medical quality assurance programs.

(2) Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

(e) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—A person or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

(f) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (a) may not be made available to any person under section 552 of title 5.

(g) LIMITATION ON CIVIL LIABILITY.—A person who participates in or provides information to a person or body that reviews or creates medical quality assurance records described in subsection (a) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

(h) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that the information was presented during meetings of a review body that are part of a medical quality assurance program.

(i) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802 of this title.

(j) DEFINITIONS.—In this section:

(1) The term 'medical quality assurance program' means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources manage-

ment review and identification and prevention of medical or dental incidents and risks.

(2) The term 'medical quality assurance record' means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (1) and are produced or compiled by or for an Indian Health Program or Urban Indian Organization as part of a medical quality assurance program.

(3) The term 'health care provider' means any health care professional, including community health aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

§ 818. Authorization of Appropriations.

(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.

(b) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking "Assistant Secretaries of Health and Human Services (6)." and inserting "Assistant Secretaries of Health and Human Services (7)".

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking "Director, Indian Health Service, Department of Health and Human Services".

(c) THREE AFFILIATED TRIBES HEALTH FACILITY COMPENSATION.—

(1) FINDINGS.—Congress finds that—

(A) in 1949, the United States assumed jurisdiction over more that 150,000 prime acres on the Fort Berthold Indian Reservation, North Dakota, for the construction of the Garrison Dam and Reservoir;

(B) the reservoir flooded and destroyed vital infrastructure on the reservation, including a hospital of the Indian Health Service;

(C) the United States made a commitment to the Three Affiliated Tribes of the Fort Berthold Indian Reservation to replace the lost infrastructure;

(D) on May 10, 1985, the Secretary of the Interior established the Garrison Unit Joint Tribal Advisory Committee to examine the effects of the Garrison Dam and Reservoir on the Fort Berthold Indian Reservation;

(E) the final report of the Committee issued on May 23, 1986, acknowledged the obligation of the Federal Government to replace the infrastructure destroyed by the Federal action;

(F) the Committee on Indian Affairs of the Senate—

(i) acknowledged the recommendations of the final report of the Committee in Senate Report No. 102–250; and

(ii) stated that every effort should be made by the Administration and Congress to provide additional Federal funding to replace the lost infrastructure; and

(G) on August 30, 2001, the Chairman of the Three Affiliated Tribes testified before the Committee on Indian Affairs of the Senate that the promise to replace the lost infrastructure, particularly the hospital, still had not been kept.

(2) RURAL HEALTH CARE FACILITY, FORT BERTHOLD INDIAN RESERVATION, NORTH DAKOTA.—The Three Affiliated Tribes and Standing Rock Sioux Tribe Equitable Compensation Act is amended—

* * * * * * *

UNITED STATES PUBLIC LAWS

102D CONGRESS—SECOND SESSION

PL 102–575, OCTOBER 30, 1992

RECLAMATION PROJECTS AUTHORIZATION AND ADJUSTMENT ACT OF 1992

SEC. 3504. FUNDS.

(a) THREE AFFILIATED TRIBES ECONOMIC RECOVERY FUND.—

(1) There is established in the Treasury of the United States the "Three Affiliated Tribes Economic Recovery Fund" (hereinafter referred to as the "Recovery Fund").

(2) Commencing with fiscal year 1993, and each fiscal year thereafter, the Secretary of the Treasury shall deposit in the Three Affiliated Tribes Economic Recovery Fund an amount, which shall be nonreimbursable and nonreturnable equal to 25 percent of the receipts from deposits to the United States Treasury for the preceding fiscal year from the integrated programs of the Eastern Division of the Pick-Sloan Missouri River Basin Project administered by the Western Area Power Administration, but in no event shall the aggregate of the amounts deposited to the Fund established by this subsection for compensation for the Three Affiliated Tribes pursuant to this paragraph and paragraph (3) exceed $149,200,000.

(3) For payment to the Three Affiliated Tribes of amounts to which they remain entitled pursuant to the Act entitled "An Act to make certain provisions in connection with the construction of the Garrison Diversion unit, Missouri River Basin Project, by the Secretary of the Interior," approved August 5, 1965 (79 Stat. 433), there is authorized to be appropriated to the Recovery Fund established by subsection (a) for fiscal year 1994 and each of the next following nine fiscal years, the sum of $6,000,000.

(4) The Secretary of the Treasury shall deposit the interest which accrues on deposits to the Three Affiliated Tribes Economic Recovery Fund in a separate account in the Treasury of the United States. Such interest shall be available, without fiscal year limitation, for use by the Secretary of the Interior, commencing with fiscal year 1998, and each fiscal year thereafter, in making payments to the Three Affiliated Tribes for use for educational, social welfare, economic development, and

other programs, subject to the approval of the Secretary. No part of the principal of the Three Affiliated Tribes Economic Development Fund shall be available for making such payments.

(b) STANDING ROCK SIOUX TRIBE ECONOMIC RECOVERY FUND.—

(1) There is established in the Treasury of the United States the "Standing Rock Sioux Tribe Economic Recovery Fund."

(2) Commencing with fiscal year 1993, and for each fiscal year thereafter, the Secretary of the Treasury shall deposit in the Standing Rock Sioux Tribe Economic Recovery Fund an amount, which shall be nonreimbursable and nonreturnable equal to 25 percent of the receipts from deposits to the United States Treasury for the preceding fiscal year from the integrated programs of the Eastern Division of the Pick-Sloan Missouri River Basin Project administered by the Western Area Power Administration, but in no event shall the aggregate of the amounts deposited to the Recovery Fund established by this subsection for compensation for the Standing Rock Sioux Tribe pursuant to this paragraph exceed $90,600,000.

(3) The Secretary of the Treasury shall deposit the interest which accrues on deposits to the Standing Rock Sioux Tribe Economic Recovery Fund in a separate account in the Treasury of the United States. Such interest shall be available, without fiscal year limitation, for use by the Secretary of the Interior, commencing with fiscal year 1998, and each fiscal year thereafter, in making payments to the Standing Rock Sioux Tribe for use for educational, social welfare, economic development, and other programs, subject to the approval of the Secretary. No part of the principal of the Standing Rock Sioux Tribe Economic Recovery Fund shall be available for making such payments.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

[SEC. 3511. AUTHORIZATION.

[There are authorized to be appropriated such sums as may be necessary to carry out the provisions of section 3504 of this title.]

§ 3511. Rural Health Care Facility, Fort Berthold Indian Reservation, North Dakota

There are authorized to be appropriated to the Secretary of Health and Human Services $20,000,000 for the construction of, and such sums as are necessary for other expenses relating to, a rural health care facility on the Fort Berthold Indian Reservation of the Three Affiliated Tribes, North Dakota.

UNITED STATES PUBLIC LAWS

106TH CONGRESS—SECOND SESSION

PL 106–310, OCTOBER 17, 2000, 114 STAT. 1101

25 U.S.C. 1671 NOTE

CHILDREN'S HEALTH ACT OF 2000

SEC. 3307. ESTABLISHMENT OF COMMISSION.

(a) IN GENERAL.—There is established a commission to be known as the Commission on Indian and Native Alaskan Health Care that shall examine the health concerns of Indians and Native Alaskans who reside on reservations and tribal lands (hereafter in this section referred to as the "Commission").

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Commission established under subsection (a) shall consist of—

(A) the Secretary;

(B) 15 members who are experts in the health care field and issues that the Commission is established to examine; and

(C) the [Director of the Indian Health Service] *Assistant Secretary for Indian Health* and the Commissioner of Indian Affairs, who shall be nonvoting members.

UNITED STATES CODE ANNOTATED

TITLE 25—INDIANS

CHAPTER 41—INDIAN LANDS OPEN DUMP CLEANUP

§ 3902. Definitions

For the purposes of this chapter, the following definitions shall apply:

(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.

(4)[(1)] CLOSURE OR CLOSE.—The term "closure or close" means the termination of operations at open dumps on Indian land or Alaska Native land and bringing such dumps into compliance with applicable Federal standards and regulations, or standards promulgated by an Indian tribal government or Alaska Native entity, if such standards are more stringent than the Federal standards and regulations.

[(2) DIRECTOR.—The term "Director" means the Director of the Indian Health Service.]

(5)[(3)] INDIAN LAND.—The term "Indian land" means—

(A) land within the limits of any Indian reservation under the jurisdiction of the United States Government, notwithstanding the issuance of any patent, and including rights-of-way running through the reservation;

(B) dependent Indian communities within the borders of the United States whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a State; and

(C) Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through such allotments.

(2)[(4)] ALASKA NATIVE LAND.—The term "Alaska Native land" means (A) land conveyed or to be conveyed pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1600 et seq.) [43 U.S.C.A. § 1601 et seq.], including any land reconveyed under section 14(c)(3) of that Act (43 U.S.C. 1613(c)(3)), and (B) land conveyed pursuant to the Act of November 2, 1966 (16 U.S.C. 1151 et seq.; commonly known as the "Fur Seal Act of 1966").

(6)[(5)] INDIAN TRIBAL GOVERNMENT.—The term "Indian tribal government" means the governing body of any Indian tribe, band, nation, pueblo, or other organized group or community which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(1)[(6)] ALASKA NATIVE ENTITY.—The term "Alaska Native entity" includes native corporations established pursuant to the Alaska Native Claims Settlement Act [43 U.S.C.A. § 1601 et seq.] and any Alaska Native village or municipal entity which owns Alaska Native land.

(7) OPEN DUMP.—The term "open dump" means any facility or site where solid waste is disposed of which is not a sanitary landfill which meets the criteria promulgated under section 4004 of the Solid Waste Disposal Act (42 U.S.C. 6944) and which is not a facility for disposal of hazardous waste.

(8) POSTCLOSURE MAINTENANCE.—The term "postclosure maintenance" means any activity undertaken at a closed solid waste management facility on Indian land or on Alaska Native land to maintain the integrity of containment features, monitor compliance with applicable performance standards, or remedy any situation or occurrence that violates regulations promulgated pursuant to subtitle D of the Solid Waste Disposal Act (42 U.S.C. 6941 et seq.).

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

(10) SOLID WASTE.—The term "solid waste" has the meaning provided that term by section 1004(27) of the Solid Waste Disposal Act (42 U.S.C. 6903) and any regulations promulgated thereunder.

§ 3903. Inventory of open dumps

(a) STUDY AND INVENTORY.—

Not later than 12 months after October 22, 1994, the [Director] *Assistant Secretary* shall conduct a study and inventory of open dumps on Indian lands and Alaska Native lands. The inventory shall list the geographic location of all open dumps, an evaluation of the contents of each dump, and an assessment of the relative severity of the threat to public health and the environment posed by each dump. Such assessment shall be carried out cooperatively with the Administrator of the Environmental Protection Agency. The Director shall obtain the concurrence of the Administrator in the determination of relative severity made by any such assessment.

(b) ANNUAL REPORTS.—

Upon completion of the study and inventory under subsection (a) of this section, the [Director] *Assistant Secretary* shall report to the Congress, and update such report annually—

(c) 10-YEAR PLAN.—

The [Director] *Assistant Secretary* shall develop and begin implementation of a 10-year plan to address solid waste disposal needs on Indian lands and Alaska Native lands. This 10-year plan shall identify—

§ 3904. Authority of [the Director of the Indian Health Service] *Assistant Secretary for Indian Health*

(a) RESERVATION INVENTORY.—

(1) Upon request by an Indian tribal government or Alaska Native entity, the [Director] *Assistant Secretary* shall—

(B) determine the relative severity of the threat to public health and the environment posed by each dump based on information available to the [Director] *Assistant Secretary* and the Indian tribal government or Alaska Native entity unless the [Director] *Assistant Secretary*, in consultation with the Indian tribal government or Alaska Native entity, determines that additional actions such as soil testing or water monitoring would be appropriate in the circumstances; and

(2) The inventory and evaluation authorized under paragraph (1)(A) shall be carried out cooperatively with the Administrator of the Environmental Protection Agency. The [Director] *Assistant Secretary* shall obtain the concurrence of the Administrator in the determination of relative severity made under paragraph (1)(B).

(b) ASSISTANCE.—

Upon completion of the activities required to be performed pursuant to subsection (a) of this section, the [Director] *Assistant Secretary* shall, subject to subsection (c) of this section, provide financial and technical assistance to the Indian tribal government or Alaska Native entity to carry out this activities necessary to—

(c) CONDITIONS.—

All assistance provided pursuant to subsection (b) of this section shall be made available on a site-specific basis in accordance with priorities developed by the [Director] *Assistant Secretary*. Priorities on specific Indian lands or Alaska Native lands shall be developed in consultation with the Indian tribal government or Alaska Native entity. The priorities shall take into account the relative severity of the threat to public health and the environment posed by each open dump and the availability of funds necessary for closure and postclosure maintenance.

§ 3905. Contact authority

(a) AUTHORITY OF [DIRECTOR] *ASSISTANT SECRETARY*.—

To the maximum extent feasible, the [Director] *Assistant Secretary* shall carry out duties under this chapter through contracts, compacts, or memoranda of agreement with Indian tribal governments or Alaska Native entities pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), section 2004a of Title 42, or section 1632 of this title.

(b) COOPERATIVE AGREEMENTS.—

The [Director] *Assistant Secretary* is authorized, for purposes of carrying out the duties of the [Director] *Assistant Secretary* under this chapter, to contract with or enter into such cooperative agreements with such other Federal agencies as is considered necessary to provide cost-sharing for closure and postclosure activities, to obtain necessary technical and financial assistance and expertise, and for such other purposes as the [Director] *Assistant Secretary* considers necessary.

§ 3906. Tribal demonstration project

(a) IN GENERAL.—

The [Director] *Assistant Secretary* may establish and carry out a program providing for demonstration projects involving open dumps on Indian land or Alaska Native land. It shall be the purpose of such project to determine if there are unique cost factors involved in the cleanup and maintenance of open dumps on such land, and the extent to which advanced closure planning is necessary. Under the program, the [Director] *Assistant Secretary* is authorized to select no less than three Indian tribal governments or Alaska Native entities to participate in such demonstration projects.

(b) CRITERIA.—

Criteria established by the [Director] *Assistant Secretary* for the selection and participation of an Indian tribal government or Alaska Native entity in the demonstration project shall provide that in order to be eligible to participate, an Indian tribal government or Alaska Native entity must—

§ 3907. Authorization of appropriations

(b) COORDINATION.—

The activities required to be performed by the [Director] *Assistant Secretary* under this chapter shall be coordinated with activities related to solid waste and sanitation facilities funded pursuant to other authorizations.

§ 3908. Disclaimers

(a) AUTHORITY OF [DIRECTOR] *ASSISTANT SECRETARY*.—

Nothing in this chapter shall be construed to alter, diminish, repeal, or supersede any authority conferred on the [Director] *Assistant Secretary* pursuant to section 1632 of this title, and section 2004a of Title 42.

UNITED STATES PUBLIC LAWS

110TH CONGRESS—SECOND SESSION

PL 100–297, APRIL 28, 1988, 102 STAT. 130

25 USC 2001 NOTE

§ 5504. Administrative Provisions

(d) FEDERAL AGENCY COOPERATION AND ASSISTANCE.—

(2) The Commissioner of the Administration for Native Americans of the Department of Health and Human Services

and the [Director of the Indian Health Service] *Assistant Secretary for Indian Health* of the Department of Health and Human Services are authorized to detail personnel to the Task Force, upon request, to enable the Task Force to carry out its functions under this part.

UNITED STATES CODE ANNOTATED

TITLE 29—LABOR

CHAPTER 16—VOCATIONAL REHABILITATION AND OTHER REHABILITATION SERVICES

Subchapter II—Research and Training

§ 763. Interagency Committee

(a) ESTABLISHMENT; MEMBERSHIP; MEETINGS.—

(1) In order to promote coordination and cooperation among Federal departments and agencies conducting rehabilitation research programs, including programs relating to assistive technology research and research that incorporates the principles of universal design, there is established within the Federal Government an Interagency Committee on Disability Research (hereinafter in this section referred to as the "Committee"), chaired by the Director and comprised of such members as the President may designate, including the following (or their designees): the Director, the Commissioner of the Rehabilitation Services Administration, the Assistant Secretary for Special Education and Rehabilitative Services, the Secretary of Education, the Secretary of Veterans Affairs, the Director of the National Institutes of Health, the Director of the National Institute of Mental Health, the Administrator of the National Aeronautics and Space Administration, the Secretary of Transportation, the Assistant Secretary of the Interior for Indian Affairs, the [Director of the Indian Health Service] *Assistant Secretary for Indian Health,* and the Director of the National Science Foundation.

UNITED STATES CODE ANNOTATED

TITLE 33—NAVIGATION AND NAVIGABLE WATERS

CHAPTER 26—WATER POLLUTION PREVENTION AND CONTROL

Subchapter V—General Provisions

§ 1377. Indian Tribes

(b) ASSESSMENT OF SEWAGE TREATMENT NEEDS; REPORT.—

The Administrator, in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health,* shall assess the need for sewage treatment works to serve Indian tribes, the degree to which such needs will be met through funds allotted

to States under section 1285 of this title and priority lists under section 1296 of this title, and any obstacles which prevent such needs from being met. Not later than one year after February 4, 1987, the Administrator shall submit a report to Congress on the assessment under this subsection, along with recommendations specifying (1) how the Administrator intends to provide assistance to Indian tribes to develop waste treatment management plans and to construct treatment works under this chapter, and (2) methods by which the participation in and administration of programs under this chapter by Indian tribes can be maximized.

(e) TREATMENT AS STATES.—

The Administrator is authorized to treat an Indian tribe as a State for purposes of subchapter II of this chapter and sections 1254, 1256, 1313, 1315, 1318, 1319, 1324, 1329, 1341, 1342, 1344, and 1346 of this title to the degree necessary to carry out the objectives of this section, but only if— . . . Such treatment as a State may include the direct provision of funds reserved under subsection (c) of this section to the governing bodies of Indian tribes, and the determination of priorities by Indian tribes, where not determined by the Administrator in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health,* is authorized to make grants under subchapter II of this chapter in an amount not to exceed 100 percent of the cost of a project

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UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 6A—PUBLIC HEALTH SERVICE

Subchapter II—General Powers and Duties

PART B—FEDERAL-STATE COOPERATION

§ 247b–14. Oral Health Promotion and Disease Prevention

(b) COMMUNITY WATER FLUORIDATION.—

(1) IN GENERAL.—

The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health,* shall establish a demonstration project that is designed to assist rural water systems in successfully implementing the water fluoridation guidelines of the Centers for Disease Control and Prevention that are entitled "Engineering and Administrative Recommendations for Water Fluoridation, 1995" (referred to in this subsection as the "EARWF").

(2) REQUIREMENTS.—

(A) COLLABORATION.—

In collaborating under paragraph (1), [the Directors referred to in such paragraph] *the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health* shall ensure that technical assistance and training are provided to tribal programs located in

each of the 12 areas of the Indian Health Service. The [Director of the Indian Health Service] *Assistant Secretary for Indian Health* shall provide coordination and administrative support to tribes under this section.

UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 6A—PUBLIC HEALTH SERVICE

Subchapter III—National Research Institutes

PART C—SPECIFIC PROVISIONS RESPECTING NATIONAL RESEARCH INSTITUTES

Subpart 1—National Cancer Institute

§ 285a–9. Grants for Education, Prevention, and Early Detection of Radiogenic Cancers and Diseases

(b) IN GENERAL.—

The Secretary, acting through the Administrator of the Health Resources and Services Administration in consultation with the Director of the National Institutes of Health and the [Director of the Indian Health Service] *Assistant Secretary for Indian Health,* may make competitive grants to any entity for the purpose of carrying out programs to—

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UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 6A—PUBLIC HEALTH SERVICE

Subchapter XII—Safety of Public Water Systems

PART E—GENERAL PROVISIONS

§ 300j–12. State Revolving Loan Funds

(i) INDIAN TRIBES.—

(2) USE OF FUNDS.—

Funds reserved pursuant to paragraph (1) shall be used to address the most significant threats to public health associated with public water systems that serve Indian Tribes, as determined by the Administrator in consultation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health* and Indian Tribes.

(4) NEEDS ASSESSMENT.—

The Administrator, in consultation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health* and Indian Tribes, shall, in accordance with a schedule that is consistent with the needs surveys conducted pursuant to subsection (h) of this section, prepare surveys and assess the

needs of drinking water treatment facilities to serve Indian Tribes, including an evaluation of the public water systems that pose the most significant threats to public health.

UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 34—ECONOMY OPPORTUNITY PROGRAM

Subchapter VIII—Native American Programs

§ 2991b–2. Establishment of Administration for Native Americans

(d) INTRA-DEPARTMENTAL COUNCIL ON NATIVE AMERICAN AFFAIRS.—

(1) There is established in the Office of the Secretary of the Intra-Departmental Council on Native American Affairs. The Commissioner shall be the chairperson of such Council and shall advise the Secretary on all matters affecting Native Americans that involve the Department. The [Director of the Indian Health Service] *Assistant Secretary for Indian Health* shall serve as vice chairperson of the Council.

UNITED STATES PUBLIC LAWS

105TH CONGRESS—FIRST SESSION

PL 105–143, DECEMBER 15, 1997, 111 STAT. 2652

MICHIGAN INDIAN LAND CLAIMS SETTLEMENT ACT

§ 203. Limitation

(b) CONSIDERATION.—

In any case in which the Secretary, acting through the [Director of the Indian Health Service] *Assistant Secretary for Indian Health,* is required to select from more that 1 application for a contract or compact described in subsection (a), in awarding the contract or compact, the Secretary shall take into consideration—

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UNITED STATES PUBLIC LAWS

91ST CONGRESS—SECOND SESSION

PL 91–557, DECEMBER 17, 1970, 84 STAT. 1485

§ 9.

Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).

UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 7—SOCIAL SECURITY

Susbchapter XIX—Grants to States for Medical Assistance Programs

§ 1396j. Indian Health [Service facilities] *Programs*

(a) ELIGIBILITY FOR [R]*R*EIMBURSEMENT FOR [M]*M*EDICAL [A]*A*SSISTANCE.—

[A facility of t]*T*he Indian Health Service *and an Indian Tribe, Tribal Organization, or an urban Indian Organization* [(including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization] (as [those] such terms are defined in section *4 of the Indian Health Care Improvement Act* [1603 of Title 25]), shall be eligible for reimbursement for medical assistance provided under a State plan *or under waiver authority with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization* if *the furnishing of such services* [and for so long as it] meets all [of] the conditions and requirements which are applicable generally to *the furnishing of items and services* [such facilities] under this *title and under such plan or waiver authority* [subchapter].

[(b) FACILITIES DEEMED TO MEET REQUIREMENTS UPON SUBMISSION OF ACCEPTABLE PLAN FOR ACHIEVING COMPLIANCE

[Notwithstanding subsection (a) of this section, a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after September 30, 1976, an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this subchapter), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months in which such plan is submitted.]

(*b*)[(c)] AUTHORITY TO ENTER INTO AGREEMENTS [AGREEMENT TO REIMBURSE STATE AGENCY FOR PROVIDING CARE AND SERVICES].—

The Secretary *may* [is authorized to] enter into *an* agreement[s] with *a* [the] State [agency] for the purpose of reimbursing *the State* [such agency] for *medical assistance* [health care and services] provided *by the* [in] Indian Health Service, *an Indian Tribe, Tribal Organizations, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care provider* [facilities] to Indians who are eligible for medical assistance under the State plan *or under waiver authority*.

(c)[(d)] DIRECT *B*[B]ILLING.—*F*[F]OR PAYMENT UNDER MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this subchapter, see section 1645 of Title 25.

UNITED STATES CODE ANNOTATED

TITLE 42—THE PUBLIC HEALTH AND WELFARE

CHAPTER 7—SOCIAL SECURITY

Subchapter XXI—State Children's Health Insurance Program

§ 1397ee. Payments to States

(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—

Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, [other than an insurance program operated or financed by the Indian Health Service,] *other than a health program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)* as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1396b(d)(2) of this title shall apply.

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