

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

S. 556

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

JULY 23, 2003
WASHINGTON, DC



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REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, JULY 23, 2003

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

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

Present: Senators Campbell, Johnson, and Murkowski.

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

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

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

[Text of S. 556 follows:]

108TH CONGRESS
1ST SESSION

S. 556

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

IN THE SENATE OF THE UNITED STATES

MARCH 6, 2003

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

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Indian Health Care Improvement Act Reauthorization of
6 2003”.

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

Sec. 1. Short title.

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

3

2

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

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL
SECURITY ACT

Subtitle A—Medicare

Sec. 201. Limitations on charges.

Sec. 202. Qualified Indian health program.

Subtitle B—Medicaid

Sec. 211. State consultation with Indian health programs.

Sec. 212. FMAP for services provided by Indian health programs.

Sec. 213. Indian Health Service programs.

Subtitle C—State Children’s Health Insurance Program

Sec. 221. Enhanced FMAP for State children’s health insurance program.

Sec. 222. Direct funding of State children’s health insurance program.

Subtitle D—Authorization of Appropriations

Sec. 231. Authorization of appropriations.

TITLE III—MISCELLANEOUS PROVISIONS

Sec. 301. Repeals.

Sec. 302. Severability provisions.

Sec. 303. Effective date.

1 **TITLE I—REAUTHORIZATION**
2 **AND REVISIONS OF THE IN-**
3 **DIAN HEALTH CARE IM-**
4 **PROVEMENT ACT**

5 **SEC. 101. AMENDMENT TO THE INDIAN HEALTH CARE IM-**
6 **PROVEMENT ACT.**

7 The Indian Health Care Improvement Act (25 U.S.C.
8 1601 et seq.) is amended to read as follows:

9 **“SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

10 “(a) SHORT TITLE.—This Act may be cited as the
11 ‘Indian Health Care Improvement Act’.

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

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

“TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND
DEVELOPMENT

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

“TITLE II—HEALTH SERVICES

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

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

“TITLE III—FACILITIES

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

“TITLE IV—ACCESS TO HEALTH SERVICES

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

- “Sec. 410. Payor of last resort.
- “Sec. 411. Right to recover from Federal health care programs.
- “Sec. 412. Tuba City demonstration project.
- “Sec. 413. Access to Federal insurance.
- “Sec. 414. Consultation and rulemaking.
- “Sec. 415. Limitations on charges.
- “Sec. 416. Limitation on Secretary’s waiver authority.
- “Sec. 417. Waiver of medicare and medicaid sanctions.
- “Sec. 418. Meaning of ‘remuneration’ for purposes of safe harbor provisions; antitrust immunity.
- “Sec. 419. Co-insurance, co-payments, deductibles and premiums.
- “Sec. 420. Inclusion of income and resources for purposes of medically needy medicaid eligibility.
- “Sec. 421. Estate recovery provisions.
- “Sec. 422. Medical child support.
- “Sec. 423. Provisions relating to managed care.
- “Sec. 424. Navajo Nation medicaid agency.
- “Sec. 425. Indian advisory committees.
- “Sec. 426. Authorization of appropriations.

“TITLE V—HEALTH SERVICES FOR URBAN INDIANS

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

“TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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

“TITLE VII—BEHAVIORAL HEALTH PROGRAMS

- “Sec. 701. Behavioral health prevention and treatment services.

- “Sec. 702. Memorandum of agreement with the Department of the Interior.
- “Sec. 703. Comprehensive behavioral health prevention and treatment program.
- “Sec. 704. Mental health technician program.
- “Sec. 705. Licensing requirement for mental health care workers.
- “Sec. 706. Indian women treatment programs.
- “Sec. 707. Indian youth program.
- “Sec. 708. Inpatient and community-based mental health facilities design, construction and staffing assessment.
- “Sec. 709. Training and community education.
- “Sec. 710. Behavioral health program.
- “Sec. 711. Fetal alcohol disorder funding.
- “Sec. 712. Child sexual abuse and prevention treatment programs.
- “Sec. 713. Behavioral mental health research.
- “Sec. 714. Definitions.
- “Sec. 715. Authorization of appropriations.

“TITLE VIII—MISCELLANEOUS

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

1 “SEC. 2. FINDINGS.

2 “Congress makes the following findings:

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

1 Constitution, treaties, Federal laws, and the course
2 of dealings of the United States with Indian tribes,
3 and the United States' resulting government to gov-
4 ernment and trust responsibility and obligations to
5 the American Indian people.

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

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

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

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

1 that of the general population, and to provide for the
2 maximum participation of Indian tribes, tribal orga-
3 nizations, and urban Indian organizations in the
4 planning, delivery, and management of those serv-
5 ices.

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

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

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

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

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

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

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

13 “(3) in order to raise the health status of In-
14 dian people to at least the levels set forth in the
15 goals contained within the Healthy People 2010, or
16 any successor standards thereto, to permit Indian
17 tribes and tribal organizations to set their own
18 health care priorities and establish goals that reflect
19 their unmet needs;

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

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

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

10 **“SEC. 4. DEFINITIONS.**

11 “In this Act:

12 “(1) ACCREDITED AND ACCESSIBLE.—The term
13 ‘accredited and accessible’, with respect to an entity,
14 means a community college or other appropriate en-
15 tity that is on or near a reservation and accredited
16 by a national or regional organization with accredit-
17 ing authority.

18 “(2) AREA OFFICE.—The term ‘area office’
19 means an administrative entity including a program
20 office, within the Indian Health Service through
21 which services and funds are provided to the service
22 units within a defined geographic area.

23 “(3) ASSISTANT SECRETARY.—The term ‘As-
24 sistant Secretary’ means the Assistant Secretary of
25 the Indian Health as established under section 601.

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

8 “(5) DEPARTMENT.—The term ‘Department’,
9 unless specifically provided otherwise, means the De-
10 partment of Health and Human Services.

11 “(6) FUND.—The terms ‘fund’ or ‘funding’
12 mean the transfer of monies from the Department
13 to any eligible entity or individual under this Act by
14 any legal means, including funding agreements, con-
15 tracts, memoranda of understanding, Buy Indian
16 Act contracts, or otherwise.

17 “(7) FUNDING AGREEMENT.—The term ‘fund-
18 ing agreement’ means any agreement to transfer
19 funds for the planning, conduct, and administration
20 of programs, functions, services and activities to
21 tribes and tribal organizations from the Secretary
22 under the authority of the Indian Self-Determination
23 and Education Assistance Act.

24 “(8) HEALTH PROFESSION.—The term ‘health
25 profession’ means allopathic medicine, family medi-

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

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

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

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

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

24 “(13) RESERVATION.—The term ‘reservation’
 25 means any federally recognized Indian tribe’s res-

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

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

8 “(15) SERVICE.—The term ‘Service’ means the
 9 Indian Health Service.

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

13 “(17) SERVICE UNIT.—The term ‘service unit’
 14 means—

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

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

24 “(18) TRADITIONAL HEALTH CARE PRAC-
 25 TICES.—The term ‘traditional health care practices’

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

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

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

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

1 “(22) URBAN INDIAN.—The term ‘urban In-
 2 dian’ means any individual who resides in an urban
 3 center and who—

4 “(A) for purposes of title V and regardless
 5 of whether such individual lives on or near a
 6 reservation, is a member of a tribe, band or
 7 other organized group of Indians, including
 8 those tribes, bands or groups terminated since
 9 1940 and those tribes, bands or groups that are
 10 recognized by the States in which they reside,
 11 or who is a descendant in the first or second
 12 degree of any such member;

13 “(B) is an Eskimo or Aleut or other Alas-
 14 kan Native;

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

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

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

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

3 **“TITLE I—INDIAN HEALTH,**
 4 **HUMAN RESOURCES AND DE-**
 5 **VELOPMENT**

6 **“SEC. 101. PURPOSE.**

7 “The purpose of this title is to increase, to the maxi-
 8 mum extent feasible, the number of Indians entering the
 9 health professions and providing health services, and to
 10 assure an optimum supply of health professionals to the
 11 Service, Indian tribes, tribal organizations, and urban In-
 12 dian organizations involved in the provision of health serv-
 13 ices to Indian people.

14 **“SEC. 102. GENERAL REQUIREMENTS.**

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

20 “(1) to be developed in consultation with Indian
 21 tribes, tribal organizations and urban Indian organi-
 22 zations;

23 “(2) that takes into account the human re-
 24 source and development needs in each such service
 25 area; and

1 “(3) that weighs the allocation of amounts ap-
2 propriated in favor of those service areas where the
3 health status of Indians within the area, as meas-
4 ured by life expectancy based upon the most recent
5 data available, is significantly lower than the average
6 health status for Indians in all service areas, except
7 that amounts allocated to each such area using such
8 a weighted allocation formula shall not be less than
9 the amounts allocated to each such area in the pre-
10 vious fiscal year.

11 “(b) CONSULTATION.—Each area office receiving
12 funds under this title shall actively and continuously con-
13 sult with representatives of Indian tribes, tribal organiza-
14 tions, and urban Indian organizations to prioritize the uti-
15 lization of funds provided under this title within the serv-
16 ice area.

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

22 “(d) LIMITATION.—This section shall not apply with
23 respect to individual recipients of scholarships, loans or
24 other funds provided under this title (as this title existed
25 1 day prior to the date of enactment of this Act) until

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

3 **“SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM**
 4 **FOR INDIANS.**

5 “(a) IN GENERAL.—The Secretary, acting through
 6 the Service, shall make funds available through the area
 7 office to public or nonprofit private health entities, or In-
 8 dian tribes or tribal organizations to assist such entities
 9 in meeting the costs of—

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

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

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

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

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

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

4 “(b) ADMINISTRATIVE PROVISIONS.—

5 “(1) APPLICATION.—To be eligible to receive
6 funds under this section an entity described in sub-
7 section (a) shall submit to the Secretary, through
8 the appropriate area office, and have approved, an
9 application in such form, submitted in such manner,
10 and containing such information as the Secretary
11 shall by regulation prescribe.

12 “(2) PREFERENCE.—In awarding funds under
13 this section, the area office shall give a preference
14 to applications submitted by Indian tribes, tribal or-
15 ganizations, or urban Indian organizations.

16 “(3) AMOUNT.—The amount of funds to be
17 provided to an eligible entity under this section shall
18 be determined by the area office. Payments under
19 this section may be made in advance or by way of
20 reimbursement, and at such intervals and on such
21 conditions as provided for in regulations promul-
22 gated pursuant to this Act.

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

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

3 “(c) DEFINITION.—For purposes of this section and
4 sections 104 and 105, the terms ‘Indian’ and ‘Indians’
5 shall, in addition to the definition provided for in section
6 4, mean any individual who—

7 “(1) irrespective of whether such individual
8 lives on or near a reservation, is a member of a
9 tribe, band, or other organized group of Indians, in-
10 cluding those tribes, bands, or groups terminated
11 since 1940;

12 “(2) is an Eskimo or Aleut or other Alaska Na-
13 tive;

14 “(3) is considered by the Secretary of the Inte-
15 rior to be an Indian for any purpose; or

16 “(4) is determined to be an Indian under regu-
17 lations promulgated by the Secretary.

18 **“SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOL-**
19 **ARSHIP PROGRAM FOR INDIANS.**

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

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

1 “(2) have demonstrated the capability to suc-
2 cessfully complete courses of study in the health pro-
3 fessions.

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

6 “(1) Compensatory preprofessional education of
7 any recipient. Such scholarship shall not exceed 2
8 years on a full-time basis (or the part-time equiva-
9 lent thereof, as determined by the area office pursu-
10 ant to regulations promulgated under this Act).

11 “(2) Pregraduate education of any recipient
12 leading to a baccalaureate degree in an approved
13 course of study preparatory to a field of study in a
14 health profession, such scholarship not to exceed 4
15 years (or the part-time equivalent thereof, as deter-
16 mined by the area office pursuant to regulations
17 promulgated under this Act) except that an exten-
18 sion of up to 2 years may be approved by the Sec-
19 retary.

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

1 “(d) LIMITATIONS.—Scholarship assistance to an eli-
2 gible applicant under this section shall not be denied solely
3 on the basis of—

4 “(1) the applicant’s scholastic achievement if
5 such applicant has been admitted to, or maintained
6 good standing at, an accredited institution; or

7 “(2) the applicant’s eligibility for assistance or
8 benefits under any other Federal program.

9 **“SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.**

10 “(a) SCHOLARSHIPS.—

11 “(1) IN GENERAL.—In order to meet the needs
12 of Indians, Indian tribes, tribal organizations, and
13 urban Indian organizations for health professionals,
14 the Secretary, acting through the Service and in ac-
15 cordance with this section, shall provide scholarships
16 through the area offices to Indians who are enrolled
17 full or part time in accredited schools and pursuing
18 courses of study in the health professions. Such
19 scholarships shall be designated Indian Health
20 Scholarships and shall, except as provided in sub-
21 section (b), be made in accordance with section
22 338A of the Public Health Service Act (42 U.S.C.
23 254l).

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

1 delegate any administrative functions under a fund-
 2 ing agreement pursuant to the Indian Self-Deter-
 3 mination and Education Assistance Act.

4 “(b) ELIGIBILITY.—

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

9 “(2) SERVICE OBLIGATION.—

10 “(A) PUBLIC HEALTH SERVICE ACT.—The
 11 active duty service obligation under a written
 12 contract with the Secretary under section 338A
 13 of the Public Health Service Act (42 U.S.C.
 14 2541) that an Indian has entered into under
 15 that section shall, if that individual is a recipi-
 16 ent of an Indian Health Scholarship, be met in
 17 full-time practice on an equivalent year for year
 18 obligation, by service—

19 “(i) in the Indian Health Service;

20 “(ii) in a program conducted under a
 21 funding agreement entered into under the
 22 Indian Self-Determination and Education
 23 Assistance Act;

24 “(iii) in a program assisted under title
 25 V; or

1 “(iv) in the private practice of the ap-
2 plicable profession if, as determined by the
3 Secretary, in accordance with guidelines
4 promulgated by the Secretary, such prac-
5 tice is situated in a physician or other
6 health professional shortage area and ad-
7 dresses the health care needs of a substan-
8 tial number of Indians.

9 “(B) DEFERRING ACTIVE SERVICE.—At
10 the request of any Indian who has entered into
11 a contract referred to in subparagraph (A) and
12 who receives a degree in medicine (including os-
13 teopathic or allopathic medicine), dentistry, op-
14 tometry, podiatry, or pharmacy, the Secretary
15 shall defer the active duty service obligation of
16 that individual under that contract, in order
17 that such individual may complete any intern-
18 ship, residency, or other advanced clinical train-
19 ing that is required for the practice of that
20 health profession, for an appropriate period (in
21 years, as determined by the Secretary), subject
22 to the following conditions:

23 “(i) No period of internship, resi-
24 dency, or other advanced clinical training
25 shall be counted as satisfying any period of

1 obligated service that is required under
2 this section.

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

8 “(iii) The active duty service obliga-
9 tion will be served in the health profession
10 of that individual, in a manner consistent
11 with clauses (i) through (iv) of subpara-
12 graph (A).

13 “(C) NEW SCHOLARSHIP RECIPIENTS.—A
14 recipient of an Indian Health Scholarship that
15 is awarded after December 31, 2003, shall meet
16 the active duty service obligation under such
17 scholarship by providing service within the serv-
18 ice area from which the scholarship was award-
19 ed. In placing the recipient for active duty the
20 area office shall give priority to the program
21 that funded the recipient, except that in cases
22 of special circumstances, a recipient may be
23 placed in a different service area pursuant to an
24 agreement between the areas or programs in-
25 volved.

1 “(D) PRIORITY IN ASSIGNMENT.—Subject
 2 to subparagraph (C), the area office, in making
 3 assignments of Indian Health Scholarship re-
 4 cipients required to meet the active duty service
 5 obligation described in subparagraph (A), shall
 6 give priority to assigning individuals to service
 7 in those programs specified in subparagraph
 8 (A) that have a need for health professionals to
 9 provide health care services as a result of indi-
 10 viduals having breached contracts entered into
 11 under this section.

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

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

20 “(B) the period of obligated service de-
 21 scribed in paragraph (2)(A) shall be equal to
 22 the greater of—

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

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

3 “(ii) two years; and

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

10 “(4) BREACH OF CONTRACT.—

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

16 “(i) fails to maintain an acceptable
17 level of academic standing in the edu-
18 cational institution in which he or she is
19 enrolled (such level determined by the edu-
20 cational institution under regulations of
21 the Secretary);

22 “(ii) is dismissed from such edu-
23 cational institution for disciplinary reasons;

24 “(iii) voluntarily terminates the train-
25 ing in such an educational institution for

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

4 “(iv) fails to accept payment, or in-
5 structs the educational institution in which
6 he or she is enrolled not to accept pay-
7 ment, in whole or in part, of a scholarship
8 under such contract;

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

14 “(B) FAILURE TO PERFORM SERVICE OB-
15 LIGATION.—If for any reason not specified in
16 subparagraph (A) an individual breaches his or
17 her written contract by failing either to begin
18 such individual’s service obligation under this
19 section or to complete such service obligation,
20 the United States shall be entitled to recover
21 from the individual an amount determined in
22 accordance with the formula specified in sub-
23 section (l) of section 110 in the manner pro-
24 vided for in such subsection.

1 “(C) DEATH.—Upon the death of an indi-
2 vidual who receives an Indian Health Scholar-
3 ship, any obligation of that individual for serv-
4 ice or payment that relates to that scholarship
5 shall be canceled.

6 “(D) WAIVER.—The Secretary shall pro-
7 vide for the partial or total waiver or suspen-
8 sion of any obligation of service or payment of
9 a recipient of an Indian Health Scholarship if
10 the Secretary, in consultation with the appro-
11 priate area office, Indian tribe, tribal organiza-
12 tion, and urban Indian organization, determines
13 that—

14 “(i) it is not possible for the recipient
15 to meet that obligation or make that pay-
16 ment;

17 “(ii) requiring that recipient to meet
18 that obligation or make that payment
19 would result in extreme hardship to the re-
20 cipient; or

21 “(iii) the enforcement of the require-
22 ment to meet the obligation or make the
23 payment would be unconscionable.

24 “(E) HARDSHIP OR GOOD CAUSE.—Not-
25 withstanding any other provision of law, in any

1 case of extreme hardship or for other good
 2 cause shown, the Secretary may waive, in whole
 3 or in part, the right of the United States to re-
 4 cover funds made available under this section.

5 “(F) BANKRUPTCY.—Notwithstanding any
 6 other provision of law, with respect to a recipi-
 7 ent of an Indian Health Scholarship, no obliga-
 8 tion for payment may be released by a dis-
 9 charge in bankruptcy under title 11, United
 10 States Code, unless that discharge is granted
 11 after the expiration of the 5-year period begin-
 12 ning on the initial date on which that payment
 13 is due, and only if the bankruptcy court finds
 14 that the nondischarge of the obligation would
 15 be unconscionable.

16 “(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PRO-
 17 GRAMS.—

18 “(1) PROVISION OF FUNDS.—

19 “(A) IN GENERAL.—The Secretary shall
 20 make funds available, through area offices, to
 21 Indian tribes and tribal organizations for the
 22 purpose of assisting such tribes and tribal orga-
 23 nizations in educating Indians to serve as
 24 health professionals in Indian communities.

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

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

11 “(2) REQUIREMENTS.—

12 “(A) IN GENERAL.—An Indian tribe or
 13 tribal organization receiving funds under para-
 14 graph (1) shall agree to provide scholarships to
 15 Indians in accordance with the requirements of
 16 this subsection.

17 “(B) MATCHING REQUIREMENT.—With re-
 18 spect to the costs of providing any scholarship
 19 pursuant to subparagraph (A)—

20 “(i) 80 percent of the costs of the
 21 scholarship shall be paid from the funds
 22 provided under paragraph (1) to the In-
 23 dian tribe or tribal organization; and

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

1 “(3) ELIGIBILITY.—An Indian tribe or tribal
2 organization shall provide scholarships under this
3 subsection only to Indians who are enrolled or ac-
4 cepted for enrollment in a course of study (approved
5 by the Secretary) in one of the health professions
6 described in this Act.

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

12 “(A) obligate such recipient to provide
13 service in an Indian health program (as defined
14 in section 110(a)(2)(A)) in the same service
15 area where the Indian tribe or tribal organiza-
16 tion providing the scholarship is located, for—

17 “(i) a number of years equal to the
18 number of years for which the scholarship
19 is provided (or the part-time equivalent
20 thereof, as determined by the Secretary),
21 or for a period of 2 years, whichever period
22 is greater; or

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

1 “(B) provide that the scholarship—

2 “(i) may only be expended for—

3 “(I) tuition expenses, other rea-
4 sonable educational expenses, and rea-
5 sonable living expenses incurred in at-
6 tendance at the educational institu-
7 tion; and

8 “(II) payment to the recipient of
9 a monthly stipend of not more than
10 the amount authorized by section
11 338(g)(1)(B) of the Public Health
12 Service Act (42 U.S.C.
13 254m(g)(1)(B), such amount to be re-
14 duced pro rata (as determined by the
15 Secretary) based on the number of
16 hours such student is enrolled, and
17 may not exceed, for any year of at-
18 tendance which the scholarship is pro-
19 vided, the total amount required for
20 the year for the purposes authorized
21 in this clause; and

22 “(ii) may not exceed, for any year of
23 attendance which the scholarship is pro-
24 vided, the total amount required for the

1 year for the purposes authorized in clause
2 (i);

3 “(C) require the recipient of such scholar-
4 ship to maintain an acceptable level of academic
5 standing as determined by the educational insti-
6 tution in accordance with regulations issued
7 pursuant to this Act; and

8 “(D) require the recipient of such scholar-
9 ship to meet the educational and licensure re-
10 quirements appropriate to the health profession
11 involved.

12 “(5) BREACH OF CONTRACT.—

13 “(A) IN GENERAL.—An individual who has
14 entered into a written contract with the Sec-
15 retary and an Indian tribe or tribal organiza-
16 tion under this subsection and who—

17 “(i) fails to maintain an acceptable
18 level of academic standing in the education
19 institution in which he or she is enrolled
20 (such level determined by the educational
21 institution under regulations of the Sec-
22 retary);

23 “(ii) is dismissed from such education
24 for disciplinary reasons;

1 “(iii) voluntarily terminates the train-
2 ing in such an educational institution for
3 which he or she has been provided a schol-
4 arship under such contract before the com-
5 pletion of such training; or

6 “(iv) fails to accept payment, or in-
7 structs the educational institution in which
8 he or she is enrolled not to accept pay-
9 ment, in whole or in part, of a scholarship
10 under such contract, in lieu of any service
11 obligation arising under such contract;

12 shall be liable to the United States for the Fed-
13 eral share of the amount which has been paid
14 to him or her, or on his or her behalf, under
15 the contract.

16 “(B) FAILURE TO PERFORM SERVICE OB-
17 LIGATION.—If for any reason not specified in
18 subparagraph (A), an individual breaches his or
19 her written contract by failing to either begin
20 such individual’s service obligation required
21 under such contract or to complete such service
22 obligation, the United States shall be entitled to
23 recover from the individual an amount deter-
24 mined in accordance with the formula specified

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

3 “(C) INFORMATION.—The Secretary may
4 carry out this subsection on the basis of infor-
5 mation received from Indian tribes or tribal or-
6 ganizations involved, or on the basis of informa-
7 tion collected through such other means as the
8 Secretary deems appropriate.

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

13 “(A) not to discriminate against an indi-
14 vidual seeking care on the basis of the ability
15 of the individual to pay for such care or on the
16 basis that payment for such care will be made
17 pursuant to the program established in title
18 XVIII of the Social Security Act or pursuant to
19 the programs established in title XIX of such
20 Act; and

21 “(B) to accept assignment under section
22 1842(b)(3)(B)(ii) of the Social Security Act for
23 all services for which payment may be made
24 under part B of title XVIII of such Act, and to
25 enter into an appropriate agreement with the

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

5 “(7) PAYMENTS.—The Secretary, through the
 6 area office, shall make payments under this sub-
 7 section to an Indian tribe or tribal organization for
 8 any fiscal year subsequent to the first fiscal year of
 9 such payments unless the Secretary or area office
 10 determines that, for the immediately preceding fiscal
 11 year, the Indian tribe or tribal organization has not
 12 complied with the requirements of this subsection.

13 **“SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
 14 **GRAM.**

15 “(a) IN GENERAL.—Notwithstanding section 102,
 16 the Secretary shall provide funds to at least 3 colleges and
 17 universities for the purpose of developing and maintaining
 18 American Indian psychology career recruitment programs
 19 as a means of encouraging Indians to enter the mental
 20 health field. These programs shall be located at various
 21 colleges and universities throughout the country to maxi-
 22 mize their availability to Indian students and new pro-
 23 grams shall be established in different locations from time
 24 to time.

1 “(b) QUENTIN N. BURDICK AMERICAN INDIANS
 2 INTO PSYCHOLOGY PROGRAM.—The Secretary shall pro-
 3 vide funds under subsection (a) to develop and maintain
 4 a program at the University of North Dakota to be known
 5 as the ‘Quentin N. Burdick American Indians Into Psy-
 6 chology Program’. Such program shall, to the maximum
 7 extent feasible, coordinate with the Quentin N. Burdick
 8 American Indians Into Nursing Program authorized under
 9 section 115, the Quentin N. Burdick Indians into Health
 10 Program authorized under section 117, and existing uni-
 11 versity research and communications networks.

12 “(c) REQUIREMENTS.—

13 “(1) REGULATIONS.—The Secretary shall pro-
 14 mulgate regulations pursuant to this Act for the
 15 competitive awarding of funds under this section.

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

19 “(A) provides outreach and recruitment for
 20 health professions to Indian communities in-
 21 cluding elementary, secondary and accredited
 22 and accessible community colleges that will be
 23 served by the program;

24 “(B) incorporates a program advisory
 25 board comprised of representatives from the

1 tribes and communities that will be served by
2 the program;

3 “(C) provides summer enrichment pro-
4 grams to expose Indian students to the various
5 fields of psychology through research, clinical,
6 and experimental activities;

7 “(D) provides stipends to undergraduate
8 and graduate students to pursue a career in
9 psychology;

10 “(E) develops affiliation agreements with
11 tribal community colleges, the Service, univer-
12 sity affiliated programs, and other appropriate
13 accredited and accessible entities to enhance the
14 education of Indian students;

15 “(F) utilizes, to the maximum extent fea-
16 sible, existing university tutoring, counseling
17 and student support services; and

18 “(G) employs, to the maximum extent fea-
19 sible, qualified Indians in the program.

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

1 “(1) in the Indian Health Service;

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

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

6 “(4) in the private practice of psychology if, as
7 determined by the Secretary, in accordance with
8 guidelines promulgated by the Secretary, such prac-
9 tice is situated in a physician or other health profes-
10 sional shortage area and addresses the health care
11 needs of a substantial number of Indians.

12 **“SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.**

13 “(a) IN GENERAL.—Any individual who receives a
14 scholarship pursuant to section 105 shall be entitled to
15 employment in the Service, or may be employed by a pro-
16 gram of an Indian tribe, tribal organization, or urban In-
17 dian organization, or other agency of the Department as
18 may be appropriate and available, during any nonacademic
19 period of the year. Periods of employment pursuant to this
20 subsection shall not be counted in determining the fulfill-
21 ment of the service obligation incurred as a condition of
22 the scholarship.

23 “(b) ENROLLEES IN COURSE OF STUDY.—Any indi-
24 vidual who is enrolled in a course of study in the health
25 professions may be employed by the Service or by an In-

1 dian tribe, tribal organization, or urban Indian organiza-
2 tion, during any nonacademic period of the year. Any such
3 employment shall not exceed 120 days during any calendar
4 year.

5 “(c) HIGH SCHOOL PROGRAMS.—Any individual who
6 is in a high school program authorized under section
7 103(a) may be employed by the Service, or by a Indian
8 tribe, tribal organization, or urban Indian organization,
9 during any nonacademic period of the year. Any such em-
10 ployment shall not exceed 120 days during any calendar
11 year.

12 “(d) ADMINISTRATIVE PROVISIONS.—Any employ-
13 ment pursuant to this section shall be made without re-
14 gard to any competitive personnel system or agency per-
15 sonnel limitation and to a position which will enable the
16 individual so employed to receive practical experience in
17 the health profession in which he or she is engaged in
18 study. Any individual so employed shall receive payment
19 for his or her services comparable to the salary he or she
20 would receive if he or she were employed in the competitive
21 system. Any individual so employed shall not be counted
22 against any employment ceiling affecting the Service or
23 the Department.

1 **“SEC. 108. CONTINUING EDUCATION ALLOWANCES.**

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

15 **“SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PRO-**
16 **GRAM.**

17 “(a) IN GENERAL.—Under the authority of the Act
18 of November 2, 1921 (25 U.S.C. 13) (commonly known
19 as the Snyder Act), the Secretary shall maintain a Com-
20 munity Health Representative Program under which the
21 Service, Indian tribes and tribal organizations—

22 “(1) provide for the training of Indians as com-
23 munity health representatives; and

24 “(2) use such community health representatives
25 in the provision of health care, health promotion,

1 and disease prevention services to Indian commu-
2 nities.

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

5 “(1) provide a high standard of training for
6 community health representatives to ensure that the
7 community health representatives provide quality
8 health care, health promotion, and disease preven-
9 tion services to the Indian communities served by
10 such Program;

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

13 “(A) combines education in the theory of
14 health care with supervised practical experience
15 in the provision of health care; and

16 “(B) provides instruction and practical ex-
17 perience in health promotion and disease pre-
18 vention activities, with appropriate consider-
19 ation given to lifestyle factors that have an im-
20 pact on Indian health status, such as alcohol-
21 ism, family dysfunction, and poverty;

22 “(3) maintain a system which identifies the
23 needs of community health representatives for con-
24 tinuing education in health care, health promotion,

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

3 “(4) maintain a system that provides close su-
 4 pervision of community health representatives;

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

8 “(6) promote traditional health care practices
 9 of the Indian tribes served consistent with the Serv-
 10 ice standards for the provision of health care, health
 11 promotion, and disease prevention.

12 **“SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT**
 13 **PROGRAM.**

14 “(a) ESTABLISHMENT.—

15 “(1) IN GENERAL.—The Secretary, acting
 16 through the Service, shall establish a program to be
 17 known as the Indian Health Service Loan Repay-
 18 ment Program (referred to in this Act as the ‘Loan
 19 Repayment Program’) in order to assure an ade-
 20 quate supply of trained health professionals nec-
 21 essary to maintain accreditation of, and provide
 22 health care services to Indians through, Indian
 23 health programs.

24 “(2) DEFINITIONS.—In this section:

1 “(A) INDIAN HEALTH PROGRAM.—The
 2 term ‘Indian health program’ means any health
 3 program or facility funded, in whole or part, by
 4 the Service for the benefit of Indians and
 5 administered—

6 “(i) directly by the Service;

7 “(ii) by any Indian tribe or tribal or
 8 Indian organization pursuant to a funding
 9 agreement under—

10 “(I) the Indian Self-Determina-
 11 tion and Educational Assistance Act;
 12 or

13 “(II) section 23 of the Act of
 14 April 30, 1908 (25 U.S.C. 47) (com-
 15 monly known as the ‘Buy-Indian
 16 Act’); or

17 “(iii) by an urban Indian organization
 18 pursuant to title V.

19 “(B) STATE.—The term ‘State’ has the
 20 same meaning given such term in section
 21 331(i)(4) of the Public Health Service Act.

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

24 “(1)(A) be enrolled—

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

7 “(ii) in an approved graduate training pro-
 8 gram in a health profession; or

9 “(B) have—

10 “(i) a degree in a health profession; and

11 “(ii) a license to practice a health profes-
 12 sion in a State;

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

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

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

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

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

25 “(c) FORMS.—

1 “(1) IN GENERAL.—In disseminating applica-
2 tion forms and contract forms to individuals desiring
3 to participate in the Loan Repayment Program, the
4 Secretary shall include with such forms a fair sum-
5 mary of the rights and liabilities of an individual
6 whose application is approved (and whose contract is
7 accepted) by the Secretary, including in the sum-
8 mary a clear explanation of the damages to which
9 the United States is entitled under subsection (1) in
10 the case of the individual’s breach of the contract.
11 The Secretary shall provide such individuals with
12 sufficient information regarding the advantages and
13 disadvantages of service as a commissioned officer
14 in the Regular or Reserve Corps of the Public
15 Health Service or a civilian employee of the Indian
16 Health Service to enable the individual to make a
17 decision on an informed basis.

18 “(2) FORMS TO BE UNDERSTANDABLE.—The
19 application form, contract form, and all other infor-
20 mation furnished by the Secretary under this section
21 shall be written in a manner calculated to be under-
22 stood by the average individual applying to partici-
23 pate in the Loan Repayment Program.

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

1 formation available to individuals desiring to partici-
2 pate in the Loan Repayment Program on a date suf-
3 ficiently early to ensure that such individuals have
4 adequate time to carefully review and evaluate such
5 forms and information.

6 “(d) PRIORITY.—

7 “(1) ANNUAL DETERMINATIONS.—The Sec-
8 retary, acting through the Service and in accordance
9 with subsection (k), shall annually—

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

13 “(B) rank those positions in order of prior-
14 ity.

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

20 “(A) give first priority to applications
21 made by individual Indians; and

22 “(B) after making determinations on all
23 applications submitted by individual Indians as
24 required under subparagraph (A), give priority
25 to—

1 “(i) individuals recruited through the
2 efforts an Indian tribe, tribal organization,
3 or urban Indian organization; and

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

6 “(e) CONTRACTS.—

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

11 “(2) NOTICE.—Not later than 21 days after
12 considering an individual for participation in the
13 Loan Repayment Program under paragraph (1), the
14 Secretary shall provide written notice to the individ-
15 ual of—

16 “(A) the Secretary’s approving of the indi-
17 vidual’s participation in the Loan Repayment
18 Program, including extensions resulting in an
19 aggregate period of obligated service in excess
20 of 4 years; or

21 “(B) the Secretary’s disapproving an indi-
22 vidual’s participation in such Program.

23 “(f) WRITTEN CONTRACT.—The written contract re-
24 ferred to in this section between the Secretary and an indi-
25 vidual shall contain—

1 “(1) an agreement under which—

2 “(A) subject to paragraph (3), the Sec-
3 retary agrees—

4 “(i) to pay loans on behalf of the indi-
5 vidual in accordance with the provisions of
6 this section; and

7 “(ii) to accept (subject to the avail-
8 ability of appropriated funds for carrying
9 out this section) the individual into the
10 Service or place the individual with a tribe,
11 tribal organization, or urban Indian orga-
12 nization as provided in subparagraph
13 (B)(iii); and

14 “(B) subject to paragraph (3), the individ-
15 ual agrees—

16 “(i) to accept loan payments on behalf
17 of the individual;

18 “(ii) in the case of an individual de-
19 scribed in subsection (b)(1)—

20 “(I) to maintain enrollment in a
21 course of study or training described
22 in subsection (b)(1)(A) until the indi-
23 vidual completes the course of study
24 or training; and

1 “(II) while enrolled in such
 2 course of study or training, to main-
 3 tain an acceptable level of academic
 4 standing (as determined under regula-
 5 tions of the Secretary by the edu-
 6 cational institution offering such
 7 course of study or training);

8 “(iii) to serve for a time period (re-
 9 ferred to in this section as the ‘period of
 10 obligated service’) equal to 2 years or such
 11 longer period as the individual may agree
 12 to serve in the full-time clinical practice of
 13 such individual’s profession in an Indian
 14 health program to which the individual
 15 may be assigned by the Secretary;

16 “(2) a provision permitting the Secretary to ex-
 17 tend for such longer additional periods, as the indi-
 18 vidual may agree to, the period of obligated service
 19 agreed to by the individual under paragraph
 20 (1)(B)(iii);

21 “(3) a provision that any financial obligation of
 22 the United States arising out of a contract entered
 23 into under this section and any obligation of the in-
 24 dividual which is conditioned thereon is contingent

1 upon funds being appropriated for loan repayments
2 under this section;

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

6 “(5) such other statements of the rights and li-
7 abilities of the Secretary and of the individual, not
8 inconsistent with this section.

9 “(g) LOAN REPAYMENTS.—

10 “(1) IN GENERAL.—A loan repayment provided
11 for an individual under a written contract under the
12 Loan Repayment Program shall consist of payment,
13 in accordance with paragraph (2), on behalf of the
14 individual of the principal, interest, and related ex-
15 penses on government and commercial loans received
16 by the individual regarding the undergraduate or
17 graduate education of the individual (or both), which
18 loans were made for—

19 “(A) tuition expenses;

20 “(B) all other reasonable educational ex-
21 penses, including fees, books, and laboratory ex-
22 penses, incurred by the individual; and

23 “(C) reasonable living expenses as deter-
24 mined by the Secretary.

25 “(2) AMOUNT OF PAYMENT.—

1 “(A) IN GENERAL.—For each year of obli-
2 gated service that an individual contracts to
3 serve under subsection (f) the Secretary may
4 pay up to \$35,000 (or an amount equal to the
5 amount specified in section 338B(g)(2)(A) of
6 the Public Health Service Act) on behalf of the
7 individual for loans described in paragraph (1).
8 In making a determination of the amount to
9 pay for a year of such service by an individual,
10 the Secretary shall consider the extent to which
11 each such determination—

12 “(i) affects the ability of the Secretary
13 to maximize the number of contracts that
14 can be provided under the Loan Repay-
15 ment Program from the amounts appro-
16 priated for such contracts;

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

20 “(iii) provides an incentive with re-
21 spect to the health professional involved re-
22 maining in an Indian health program with
23 such a health professional shortage, and
24 continuing to provide primary health serv-
25 ices, after the completion of the period of

1 obligated service under the Loan Repay-
2 ment Program.

3 “(B) TIME FOR PAYMENT.—Any arrange-
4 ment made by the Secretary for the making of
5 loan repayments in accordance with this sub-
6 section shall provide that any repayments for a
7 year of obligated service shall be made not later
8 than the end of the fiscal year in which the in-
9 dividual completes such year of service.

10 “(3) SCHEDULE FOR PAYMENTS.—The Sec-
11 retary may enter into an agreement with the holder
12 of any loan for which payments are made under the
13 Loan Repayment Program to establish a schedule
14 for the making of such payments.

15 “(h) COUNTING OF INDIVIDUALS.—Notwithstanding
16 any other provision of law, individuals who have entered
17 into written contracts with the Secretary under this sec-
18 tion, while undergoing academic training, shall not be
19 counted against any employment ceiling affecting the De-
20 partment.

21 “(i) RECRUITING PROGRAMS.—The Secretary shall
22 conduct recruiting programs for the Loan Repayment Pro-
23 gram and other health professional programs of the Serv-
24 ice at educational institutions training health professionals
25 or specialists identified in subsection (a).

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

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

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

14 “(2) give priority to assigning individuals to In-
15 dian health programs that have a need for health
16 professionals to provide health care services as a re-
17 sult of individuals having breached contracts entered
18 into under this section.

19 “(l) BREACH OF CONTRACT.—

20 “(1) IN GENERAL.—An individual who has en-
21 tered into a written contract with the Secretary
22 under this section and who—

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

1 “(i) fails to maintain an acceptable
2 level of academic standing in the edu-
3 cational institution in which he is enrolled
4 (such level determined by the educational
5 institution under regulations of the Sec-
6 retary);

7 “(ii) voluntarily terminates such en-
8 rollment; or

9 “(iii) is dismissed from such edu-
10 cational institution before completion of
11 such course of study; or

12 “(B) is enrolled in a graduate training pro-
13 gram, and who fails to complete such training
14 program, and does not receive a waiver from
15 the Secretary under subsection (b)(1)(B)(ii),
16 shall be liable, in lieu of any service obligation aris-
17 ing under such contract, to the United States for the
18 amount which has been paid on such individual’s be-
19 half under the contract.

20 “(2) AMOUNT OF RECOVERY.—If, for any rea-
21 son not specified in paragraph (1), an individual
22 breaches his written contract under this section by
23 failing either to begin, or complete, such individual’s
24 period of obligated service in accordance with sub-
25 section (f), the United States shall be entitled to re-

1 cover from such individual an amount to be deter-
 2 mined in accordance with the following formula:

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

4 in which—

5 “(A) ‘A’ is the amount the United States
 6 is entitled to recover;

7 “(B) ‘Z’ is the sum of the amounts paid
 8 under this section to, or on behalf of, the indi-
 9 vidual and the interest on such amounts which
 10 would be payable if, at the time the amounts
 11 were paid, they were loans bearing interest at
 12 the maximum legal prevailing rate, as deter-
 13 mined by the Treasurer of the United States;

14 “(C) ‘t’ is the total number of months in
 15 the individual’s period of obligated service in
 16 accordance with subsection (f); and

17 “(D) ‘s’ is the number of months of such
 18 period served by such individual in accordance
 19 with this section.

20 Amounts not paid within such period shall be sub-
 21 ject to collection through deductions in medicare
 22 payments pursuant to section 1892 of the Social Se-
 23 curity Act.

24 “(3) DAMAGES.—

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

8 “(B) DELINQUENCIES.—If damages de-
9 scribed in subparagraph (A) are delinquent for
10 3 months, the Secretary shall, for the purpose
11 of recovering such damages—

12 “(i) utilize collection agencies con-
13 tracted with by the Administrator of the
14 General Services Administration; or

15 “(ii) enter into contracts for the re-
16 covery of such damages with collection
17 agencies selected by the Secretary.

18 “(C) CONTRACTS FOR RECOVERY OF DAM-
19 AGES.—Each contract for recovering damages
20 pursuant to this subsection shall provide that
21 the contractor will, not less than once each 6
22 months, submit to the Secretary a status report
23 on the success of the contractor in collecting
24 such damages. Section 3718 of title 31, United

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

3 “(m) CANCELLATION, WAIVER OR RELEASE.—

4 “(1) CANCELLATION.—Any obligation of an in-
5 dividual under the Loan Repayment Program for
6 service or payment of damages shall be canceled
7 upon the death of the individual.

8 “(2) WAIVER OF SERVICE OBLIGATION.—The
9 Secretary shall by regulation provide for the partial
10 or total waiver or suspension of any obligation of
11 service or payment by an individual under the Loan
12 Repayment Program whenever compliance by the in-
13 dividual is impossible or would involve extreme hard-
14 ship to the individual and if enforcement of such ob-
15 ligation with respect to any individual would be un-
16 conscionable.

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

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

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

7 “(n) REPORT.—The Secretary shall submit to the
8 President, for inclusion in each report required to be sub-
9 mitted to the Congress under section 801, a report con-
10 cerning the previous fiscal year which sets forth—

11 “(1) the health professional positions main-
12 tained by the Service or by tribal or Indian organi-
13 zations for which recruitment or retention is dif-
14 ficult;

15 “(2) the number of Loan Repayment Program
16 applications filed with respect to each type of health
17 profession;

18 “(3) the number of contracts described in sub-
19 section (f) that are entered into with respect to each
20 health profession;

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

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

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

3 “(7) the number of providers of health care
4 that will be needed by Indian health programs, by
5 location and profession, during the 3 fiscal years be-
6 ginning after the date the report is filed; and

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

12 **“SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOV-
13 ERY FUND.**

14 “(a) ESTABLISHMENT.—Notwithstanding section
15 102, there is established in the Treasury of the United
16 States a fund to be known as the Indian Health Scholar-
17 ship and Loan Repayment Recovery Fund (referred to in
18 this section as the ‘LRRF’). The LRRF Fund shall con-
19 sist of—

20 “(1) such amounts as may be collected from in-
21 dividuals under subparagraphs (A) and (B) of sec-
22 tion 105(b)(4) and section 110(l) for breach of con-
23 tract;

24 “(2) such funds as may be appropriated to the
25 LRRF;

1 “(3) such interest earned on amounts in the
2 LRRF; and

3 “(4) such additional amounts as may be col-
4 lected, appropriated, or earned relative to the
5 LRRF.

6 Amounts appropriated to the LRRF shall remain available
7 until expended.

8 “(b) USE OF LRRF.—

9 “(1) IN GENERAL.—Amounts in the LRRF
10 may be expended by the Secretary, subject to section
11 102, acting through the Service, to make payments
12 to the Service or to an Indian tribe or tribal organi-
13 zation administering a health care program pursuant
14 to a funding agreement entered into under the In-
15 dian Self-Determination and Education Assistance
16 Act—

17 “(A) to which a scholarship recipient under
18 section 105 or a loan repayment program par-
19 ticipant under section 110 has been assigned to
20 meet the obligated service requirements pursu-
21 ant to sections; and

22 “(B) that has a need for a health profes-
23 sional to provide health care services as a result
24 of such recipient or participant having breached

1 the contract entered into under section 105 or
2 section 110.

3 “(2) SCHOLARSHIPS AND RECRUITING.—An In-
4 dian tribe or tribal organization receiving payments
5 pursuant to paragraph (1) may expend the payments
6 to provide scholarships or to recruit and employ, di-
7 rectly or by contract, health professionals to provide
8 health care services.

9 “(c) INVESTING OF FUND.—

10 “(1) IN GENERAL.—The Secretary of the
11 Treasury shall invest such amounts of the LRRF as
12 the Secretary determines are not required to meet
13 current withdrawals from the LRRF. Such invest-
14 ments may be made only in interest-bearing obliga-
15 tions of the United States. For such purpose, such
16 obligations may be acquired on original issue at the
17 issue price, or by purchase of outstanding obliga-
18 tions at the market price.

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

22 **“SEC. 112. RECRUITMENT ACTIVITIES.**

23 “(a) REIMBURSEMENT OF EXPENSES.—The Sec-
24 retary may reimburse health professionals seeking posi-
25 tions in the Service, Indian tribes, tribal organizations, or

1 urban Indian organizations, including unpaid student vol-
2 unteers and individuals considering entering into a con-
3 tract under section 110, and their spouses, for actual and
4 reasonable expenses incurred in traveling to and from
5 their places of residence to an area in which they may
6 be assigned for the purpose of evaluating such area with
7 respect to such assignment.

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

12 **“SEC. 113. TRIBAL RECRUITMENT AND RETENTION PRO-**
13 **GRAM.**

14 “(a) FUNDING OF PROJECTS.—The Secretary, acting
15 through the Service, shall fund innovative projects for a
16 period not to exceed 3 years to enable Indian tribes, tribal
17 organizations, and urban Indian organizations to recruit,
18 place, and retain health professionals to meet the staffing
19 needs of Indian health programs (as defined in section
20 110(a)(2)(A)).

21 “(b) ELIGIBILITY.—Any Indian tribe, tribal organi-
22 zation, or urban Indian organization may submit an appli-
23 cation for funding of a project pursuant to this section.

1 **“SEC. 114. ADVANCED TRAINING AND RESEARCH.**

2 “(a) DEMONSTRATION PROJECT.—The Secretary,
3 acting through the Service, shall establish a demonstration
4 project to enable health professionals who have worked in
5 an Indian health program (as defined in section 110) for
6 a substantial period of time to pursue advanced training
7 or research in areas of study for which the Secretary de-
8 termines a need exists.

9 “(b) SERVICE OBLIGATION.—

10 “(1) IN GENERAL.—An individual who partici-
11 pates in the project under subsection (a), where the
12 educational costs are borne by the Service, shall
13 incur an obligation to serve in an Indian health pro-
14 gram for a period of obligated service equal to at
15 least the period of time during which the individual
16 participates in such project.

17 “(2) FAILURE TO COMPLETE SERVICE.—In the
18 event that an individual fails to complete a period of
19 obligated service under paragraph (1), the individual
20 shall be liable to the United States for the period of
21 service remaining. In such event, with respect to in-
22 dividuals entering the project after the date of the
23 enactment of this Act, the United States shall be en-
24 titled to recover from such individual an amount to
25 be determined in accordance with the formula speci-

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

3 “(c) OPPORTUNITY TO PARTICIPATE.—Health pro-
4 fessionals from Indian tribes, tribal organizations, and
5 urban Indian organizations under the authority of the In-
6 dian Self-Determination and Education Assistance Act
7 shall be given an equal opportunity to participate in the
8 program under subsection (a).

9 **“SEC. 115. NURSING PROGRAMS; QUENTIN N. BURDICK**
10 **AMERICAN INDIANS INTO NURSING PRO-**
11 **GRAM.**

12 “(a) GRANTS.—Notwithstanding section 102, the
13 Secretary, acting through the Service, shall provide funds
14 to—

15 “(1) public or private schools of nursing;

16 “(2) tribally controlled community colleges and
17 tribally controlled postsecondary vocational institu-
18 tions (as defined in section 390(2) of the Tribally
19 Controlled Vocational Institutions Support Act of
20 1990 (20 U.S.C. 2397h(2)); and

21 “(3) nurse midwife programs, and advance
22 practice nurse programs, that are provided by any
23 tribal college accredited nursing program, or in the
24 absence of such, any other public or private institu-
25 tion,

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

4 “(b) USE OF GRANTS.—Funds provided under sub-
5 section (a) may be used to—

6 “(1) recruit individuals for programs which
7 train individuals to be nurses, nurse midwives, or
8 advanced practice nurses;

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

15 “(3) provide a program that encourages nurses,
16 nurse midwives, and advanced practice nurses to
17 provide, or continue to provide, health care services
18 to Indians;

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

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

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

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

4 “(d) PREFERENCES.—In providing funds under sub-
5 section (a), the Secretary shall extend a preference to—

6 “(1) programs that provide a preference to In-
7 dians;

8 “(2) programs that train nurse midwives or ad-
9 vanced practice nurses;

10 “(3) programs that are interdisciplinary; and

11 “(4) programs that are conducted in coopera-
12 tion with a center for gifted and talented Indian stu-
13 dents established under section 5324(a) of the In-
14 dian Education Act of 1988.

15 “(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO
16 NURSING PROGRAM.—The Secretary shall ensure that a
17 portion of the funds authorized under subsection (a) is
18 made available to establish and maintain a program at the
19 University of North Dakota to be known as the ‘Quentin
20 N. Burdick American Indians Into Nursing Program’.
21 Such program shall, to the maximum extent feasible, co-
22 ordinate with the Quentin N. Burdick American Indians
23 Into Psychology Program established under section 106(b)
24 and the Quentin N. Burdick Indian Health Programs es-
25 tablished under section 117(b).

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

8 “(1) in the Indian Health Service;

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

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

13 “(4) in the private practice of nursing if, as de-
14 termined by the Secretary, in accordance with guide-
15 lines promulgated by the Secretary, such practice is
16 situated in a physician or other health professional
17 shortage area and addresses the health care needs of
18 a substantial number of Indians.

19 **“SEC. 116. TRIBAL CULTURE AND HISTORY.**

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

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

4 “(1) be provided in consultation with the af-
5 fected tribal governments, tribal organizations, and
6 urban Indian organizations;

7 “(2) be provided through tribally-controlled
8 community colleges (within the meaning of section
9 2(4) of the Tribally Controlled Community College
10 Assistance Act of 1978) and tribally controlled post-
11 secondary vocational institutions (as defined in sec-
12 tion 390(2) of the Tribally Controlled Vocational In-
13 stitutions Support Act of 1990 (20 U.S.C.
14 2397h(2)); and

15 “(3) include instruction in Native American
16 studies.

17 **“SEC. 117. INMED PROGRAM.**

18 “(a) GRANTS.—The Secretary may provide grants to
19 3 colleges and universities for the purpose of maintaining
20 and expanding the Native American health careers recruit-
21 ment program known as the ‘Indians into Medicine Pro-
22 gram’ (referred to in this section as ‘INMED’) as a means
23 of encouraging Indians to enter the health professions.

24 “(b) QUENTIN N. BURDICK INDIAN HEALTH PRO-
25 GRAM.—The Secretary shall provide 1 of the grants under

1 subsection (a) to maintain the INMED program at the
 2 University of North Dakota, to be known as the ‘Quentin
 3 N. Burdick Indian Health Program’, unless the Secretary
 4 makes a determination, based upon program reviews, that
 5 the program is not meeting the purposes of this section.
 6 Such program shall, to the maximum extent feasible, co-
 7 ordinate with the Quentin N. Burdick American Indians
 8 Into Psychology Program established under section 106(b)
 9 and the Quentin N. Burdick American Indians Into Nurs-
 10 ing Program established under section 115.

11 “(c) REQUIREMENTS.—

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

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

17 “(A) provides outreach and recruitment for
 18 health professions to Indian communities in-
 19 cluding elementary, secondary and community
 20 colleges located on Indian reservations which
 21 will be served by the program;

22 “(B) incorporates a program advisory
 23 board comprised of representatives from the
 24 tribes and communities which will be served by
 25 the program;

1 “(C) provides summer preparatory pro-
 2 grams for Indian students who need enrichment
 3 in the subjects of math and science in order to
 4 pursue training in the health professions;

5 “(D) provides tutoring, counseling and
 6 support to students who are enrolled in a health
 7 career program of study at the respective col-
 8 lege or university; and

9 “(E) to the maximum extent feasible, em-
 10 ploys qualified Indians in the program.

11 **“SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY**
 12 **COLLEGES.**

13 “(a) ESTABLISHMENT GRANTS.—

14 “(1) IN GENERAL.—The Secretary, acting
 15 through the Service, shall award grants to accredited
 16 and accessible community colleges for the purpose of
 17 assisting such colleges in the establishment of pro-
 18 grams which provide education in a health profes-
 19 sion leading to a degree or diploma in a health pro-
 20 fession for individuals who desire to practice such
 21 profession on an Indian reservation, in the Service,
 22 or in a tribal health program.

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

1 vided to the community college shall not exceed
2 \$100,000.

3 “(b) CONTINUATION GRANTS.—

4 “(1) IN GENERAL.—The Secretary, acting
5 through the Service, shall award grants to accredited
6 and accessible community colleges that have estab-
7 lished a program described in subsection (a)(1) for
8 the purpose of maintaining the program and recruit-
9 ing students for the program.

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

12 “(A) is accredited;

13 “(B) has a relationship with a hospital fa-
14 cility, Service facility, or hospital that could
15 provide training of nurses or health profes-
16 sionals;

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

20 “(i) provide a program that enhances
21 the transition and recruitment of students
22 into advanced baccalaureate or graduate
23 programs which train health professionals;
24 and

1 “(ii) stipulate certifications necessary
2 to approve internship and field placement
3 opportunities at health programs of the
4 Service or at tribal health programs;

5 “(D) has a qualified staff which has the
6 appropriate certifications;

7 “(E) is capable of obtaining State or re-
8 gional accreditation of the program described in
9 subsection (a)(1); and

10 “(F) agrees to provide for Indian pref-
11 erence for applicants for programs under this
12 section.

13 “(c) SERVICE PERSONNEL AND TECHNICAL ASSIST-
14 ANCE.—The Secretary shall encourage community colleges
15 described in subsection (b)(2) to establish and maintain
16 programs described in subsection (a)(1) by—

17 “(1) entering into agreements with such col-
18 leges for the provision of qualified personnel of the
19 Service to teach courses of study in such programs,
20 and

21 “(2) providing technical assistance and support
22 to such colleges.

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

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

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

5 “(2) provides clinical services on an Indian res-
 6 ervation, at a Service facility, or at a tribal clinic.

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

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

14 “(f) DEFINITIONS.—In this section:

15 “(1) COMMUNITY COLLEGE.—The term ‘com-
 16 munity college’ means—

17 “(A) a tribally controlled community col-
 18 lege; or

19 “(B) a junior or community college.

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

24 “(3) TRIBALLY CONTROLLED COLLEGE.—The
 25 term ‘tribally controlled college’ has the meaning

1 given the term ‘tribally controlled community college’
 2 by section 2(4) of the Tribally Controlled Commu-
 3 nity College Assistance Act of 1978.

4 **“SEC. 119. RETENTION BONUS.**

5 “(a) IN GENERAL.—The Secretary may pay a reten-
 6 tion bonus to any health professional employed by, or as-
 7 signed to, and serving in, the Service, an Indian tribe, a
 8 tribal organization, or an urban Indian organization either
 9 as a civilian employee or as a commissioned officer in the
 10 Regular or Reserve Corps of the Public Health Service
 11 who—

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

15 “(2) the Secretary determines is needed by the
 16 Service, tribe, tribal organization, or urban organiza-
 17 tion;

18 “(3) has—

19 “(A) completed 3 years of employment
 20 with the Service; tribe, tribal organization, or
 21 urban organization; or

22 “(B) completed any service obligations in-
 23 curred as a requirement of—

24 “(i) any Federal scholarship program;
 25 or

1 “(ii) any Federal education loan re-
2 payment program; and

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

7 “(b) RATES.—The Secretary may establish rates for
8 the retention bonus which shall provide for a higher an-
9 nual rate for multiyear agreements than for single year
10 agreements referred to in subsection (a)(4), but in no
11 event shall the annual rate be more than \$25,000 per
12 annum.

13 “(c) FAILURE TO COMPLETE TERM OF SERVICE.—
14 Any health professional failing to complete the agreed
15 upon term of service, except where such failure is through
16 no fault of the individual, shall be obligated to refund to
17 the Government the full amount of the retention bonus
18 for the period covered by the agreement, plus interest as
19 determined by the Secretary in accordance with section
20 110(l)(2)(B).

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

1 health professional is serving in a position which the Sec-
2 retary determines is—

3 “(1) a position for which recruitment or reten-
4 tion is difficult; and

5 “(2) necessary for providing health care services
6 to Indians.

7 **“SEC. 120. NURSING RESIDENCY PROGRAM.**

8 “(a) ESTABLISHMENT.—The Secretary, acting
9 through the Service, shall establish a program to enable
10 Indians who are licensed practical nurses, licensed voca-
11 tional nurses, and registered nurses who are working in
12 an Indian health program (as defined in section
13 110(a)(2)(A)), and have done so for a period of not less
14 than 1 year, to pursue advanced training.

15 “(b) REQUIREMENT.—The program established
16 under subsection (a) shall include a combination of edu-
17 cation and work study in an Indian health program (as
18 defined in section 110(a)(2)(A)) leading to an associate
19 or bachelor’s degree (in the case of a licensed practical
20 nurse or licensed vocational nurse) or a bachelor’s degree
21 (in the case of a registered nurse) or an advanced degree
22 in nursing and public health.

23 “(c) SERVICE OBLIGATION.—An individual who par-
24 ticipates in a program under subsection (a), where the
25 educational costs are paid by the Service, shall incur an

1 obligation to serve in an Indian health program for a pe-
 2 riod of obligated service equal to the amount of time dur-
 3 ing which the individual participates in such program. In
 4 the event that the individual fails to complete such obli-
 5 gated service, the United States shall be entitled to recover
 6 from such individual an amount determined in accordance
 7 with the formula specified in subsection (l) of section 110
 8 in the manner provided for in such subsection.

9 **“SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALAS-**

10 **KA.**

11 “(a) IN GENERAL.—Under the authority of the Act
 12 of November 2, 1921 (25 U.S.C. 13; commonly known as
 13 the Snyder Act), the Secretary shall maintain a Commu-
 14 nity Health Aide Program in Alaska under which the
 15 Service—

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

18 “(2) uses such aides or practitioners in the pro-
 19 vision of health care, health promotion, and disease
 20 prevention services to Alaska Natives living in vil-
 21 lages in rural Alaska; and

22 “(3) provides for the establishment of tele-
 23 conferencing capacity in health clinics located in or
 24 near such villages for use by community health aides
 25 or community health practitioners.

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

4 “(1) using trainers accredited by the Program,
5 provide a high standard of training to community
6 health aides and community health practitioners to
7 ensure that such aides and practitioners provide
8 quality health care, health promotion, and disease
9 prevention services to the villages served by the Pro-
10 gram;

11 “(2) in order to provide such training, develop
12 a curriculum that—

13 “(A) combines education in the theory of
14 health care with supervised practical experience
15 in the provision of health care;

16 “(B) provides instruction and practical ex-
17 perience in the provision of acute care, emer-
18 gency care, health promotion, disease preven-
19 tion, and the efficient and effective manage-
20 ment of clinic pharmacies, supplies, equipment,
21 and facilities; and

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

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

1 community health aides or community health practition-
2 ers individuals who have successfully completed the
3 training described in paragraph (1) or who can dem-
4 onstrate equivalent experience;

5 “(4) develop and maintain a system which iden-
6 tifies the needs of community health aides and com-
7 munity health practitioners for continuing education
8 in the provision of health care, including the areas
9 described in paragraph (2)(B), and develop pro-
10 grams that meet the needs for such continuing edu-
11 cation;

12 “(5) develop and maintain a system that pro-
13 vides close supervision of community health aides
14 and community health practitioners; and

15 “(6) develop a system under which the work of
16 community health aides and community health prac-
17 titioners is reviewed and evaluated to assure the pro-
18 vision of quality health care, health promotion, and
19 disease prevention services.

20 **“SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.**

21 “Subject to Section 102, the Secretary, acting
22 through the Service, shall, through a funding agreement
23 or otherwise, provide training for Indians in the adminis-
24 tration and planning of tribal health programs.

1 **“SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE**
2 **DEMONSTRATION PROJECT.**

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

7 “(b) PURPOSE.—It is the purpose of the health pro-
8 fessions demonstration project under this section to—

9 “(1) provide direct clinical and practical experi-
10 ence in a service area to health professions students
11 and residents from medical schools;

12 “(2) improve the quality of health care for Indi-
13 ans by assuring access to qualified health care pro-
14 fessionals; and

15 “(3) provide academic and scholarly opportuni-
16 ties for health professionals serving Indian people by
17 identifying and utilizing all academic and scholarly
18 resources of the region.

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

24 **“SEC. 124. SCHOLARSHIPS.**

25 “Scholarships and loan reimbursements provided to
26 individuals pursuant to this title shall be treated as ‘quali-

1 fied scholarships’ for purposes of section 117 of the Inter-
 2 nal Revenue Code of 1986.

3 **“SEC. 125. NATIONAL HEALTH SERVICE CORPS.**

4 “(a) LIMITATIONS.—The Secretary shall not—

5 “(1) remove a member of the National Health
 6 Services Corps from a health program operated by
 7 Indian Health Service or by a tribe or tribal organi-
 8 zation under a funding agreement with the Service
 9 under the Indian Self-Determination and Education
 10 Assistance Act, or by urban Indian organizations; or

11 “(2) withdraw the funding used to support such
 12 a member;

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

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

1 “(c) FULL TIME EQUIVALENT.—National Health
 2 Service Corps scholars that qualify for the commissioned
 3 corps in the Public Health Service shall be exempt from
 4 the full time equivalent limitations of the National Health
 5 Service Corps and the Service when such scholars serve
 6 as commissioned corps officers in a health program oper-
 7 ated by an Indian tribe or tribal organization under the
 8 Indian Self-Determination and Education Assistance Act
 9 or by an urban Indian organization.

10 **“SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION**
 11 **DEMONSTRATION PROJECT.**

12 “(a) DEMONSTRATION PROJECTS.—The Secretary,
 13 acting through the Service, may enter into contracts with,
 14 or make grants to, accredited tribally controlled commu-
 15 nity colleges, tribally controlled postsecondary vocational
 16 institutions, and eligible accredited and accessible commu-
 17 nity colleges to establish demonstration projects to develop
 18 educational curricula for substance abuse counseling.

19 “(b) USE OF FUNDS.—Funds provided under this
 20 section shall be used only for developing and providing
 21 educational curricula for substance abuse counseling (in-
 22 cluding paying salaries for instructors). Such curricula
 23 may be provided through satellite campus programs.

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

1 of 1 year. Such contract or grant may be renewed for an
2 additional 1 year period upon the approval of the Sec-
3 retary.

4 “(d) REVIEW OF APPLICATIONS.—Not later than 180
5 days after the date of the enactment of this Act, the Sec-
6 retary, after consultation with Indian tribes and adminis-
7 trators of accredited tribally controlled community col-
8 leges, tribally controlled postsecondary vocational institu-
9 tions, and eligible accredited and accessible community
10 colleges, shall develop and issue criteria for the review and
11 approval of applications for funding (including applica-
12 tions for renewals of funding) under this section. Such cri-
13 teria shall ensure that demonstration projects established
14 under this section promote the development of the capacity
15 of such entities to educate substance abuse counselors.

16 “(e) TECHNICAL ASSISTANCE.—The Secretary shall
17 provide such technical and other assistance as may be nec-
18 essary to enable grant recipients to comply with the provi-
19 sions of this section.

20 “(f) REPORT.—The Secretary shall submit to the
21 President, for inclusion in the report required to be sub-
22 mitted under section 801 for fiscal year 1999, a report
23 on the findings and conclusions derived from the dem-
24 onstration projects conducted under this section.

25 “(g) DEFINITIONS.—In this section:

1 “(1) EDUCATIONAL CURRICULUM.—The term
2 ‘educational curriculum’ means 1 or more of the fol-
3 lowing:

4 “(A) Classroom education.

5 “(B) Clinical work experience.

6 “(C) Continuing education workshops.

7 “(2) TRIBALLY CONTROLLED COMMUNITY COL-
8 LEGE.—The term ‘tribally controlled community col-
9 lege’ has the meaning given such term in section
10 2(a)(4) of the Tribally Controlled Community Col-
11 lege Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

12 “(3) TRIBALLY CONTROLLED POSTSECONDARY
13 VOCATIONAL INSTITUTION.—The term ‘tribally con-
14 trolled postsecondary vocational institution’ has the
15 meaning given such term in section 390(2) of the
16 Tribally Controlled Vocational Institutions Support
17 Act of 1990 (20 U.S.C. 2397h(2)).

18 **“SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY**
19 **EDUCATION.**

20 “(a) STUDY AND LIST.—

21 “(1) IN GENERAL.—The Secretary and the Sec-
22 retary of the Interior in consultation with Indian
23 tribes and tribal organizations shall conduct a study
24 and compile a list of the types of staff positions
25 specified in subsection (b) whose qualifications in-

1 clude or should include, training in the identifica-
 2 tion, prevention, education, referral or treatment of
 3 mental illness, dysfunctional or self-destructive be-
 4 havior.

5 “(2) POSITIONS.—The positions referred to in
 6 paragraph (1) are—

7 “(A) staff positions within the Bureau of
 8 Indian Affairs, including existing positions, in
 9 the fields of—

10 “(i) elementary and secondary edu-
 11 cation;

12 “(ii) social services, family and child
 13 welfare;

14 “(iii) law enforcement and judicial
 15 services; and

16 “(iv) alcohol and substance abuse;

17 “(B) staff positions within the Service; and

18 “(C) staff positions similar to those speci-
 19 fied in subsection (b) and established and main-
 20 tained by Indian tribes, tribal organizations,
 21 and urban Indian organizations, including posi-
 22 tions established pursuant to funding agree-
 23 ments under the Indian Self-determination and
 24 Education Assistance Act, and this Act.

25 “(3) TRAINING CRITERIA.—

1 “(A) IN GENERAL.—The appropriate Sec-
2 retary shall provide training criteria appropriate
3 to each type of position specified in subsection
4 (b)(1) and ensure that appropriate training has
5 been or will be provided to any individual in any
6 such position.

7 “(B) TRAINING.—With respect to any such
8 individual in a position specified pursuant to
9 subsection (b)(3), the respective Secretaries
10 shall provide appropriate training or provide
11 funds to an Indian tribe, tribal organization, or
12 urban Indian organization for the training of
13 appropriate individuals. In the case of a fund-
14 ing agreement, the appropriate Secretary shall
15 ensure that such training costs are included in
16 the funding agreement, if necessary.

17 “(4) CULTURAL RELEVANCY.—Position specific
18 training criteria shall be culturally relevant to Indi-
19 ans and Indian tribes and shall ensure that appro-
20 priate information regarding traditional health care
21 practices is provided.

22 “(5) COMMUNITY EDUCATION.—

23 “(A) DEVELOPMENT.—The Service shall
24 develop and implement, or on request of an In-
25 dian tribe or tribal organization, assist an In-

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

4 “(B) TECHNICAL ASSISTANCE.—In carry-
5 ing out this paragraph, the Service shall, upon
6 the request of an Indian tribe or tribal organi-
7 zation, provide technical assistance to the In-
8 dian tribe or tribal organization to obtain and
9 develop community educational materials on the
10 identification, prevention, referral and treat-
11 ment of mental illness, dysfunctional and self-
12 destructive behavior.

13 “(b) STAFFING.—

14 “(1) IN GENERAL.—Not later than 90 days
15 after the date of enactment of the Act, the Director
16 of the Service shall develop a plan under which the
17 Service will increase the number of health care staff
18 that are providing mental health services by at least
19 500 positions within 5 years after such date of en-
20 actment, with at least 200 of such positions devoted
21 to child, adolescent, and family services. The alloca-
22 tion of such positions shall be subject to the provi-
23 sions of section 102(a).

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

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

3 **“SEC. 128. AUTHORIZATION OF APPROPRIATIONS.**

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

7 **“TITLE II—HEALTH SERVICES**

8 **“SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.**

9 “(a) IN GENERAL.—The Secretary may expend
10 funds, directly or under the authority of the Indian Self-
11 Determination and Education Assistance Act, that are ap-
12 propriated under the authority of this section, for the pur-
13 poses of—

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

16 “(2) eliminating backlogs in the provision of
17 health care services to Indians;

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

20 “(4) eliminating inequities in funding for both
21 direct care and contract health service programs;
22 and

23 “(5) augmenting the ability of the Service to
24 meet the following health service responsibilities with

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

3 “(A) clinical care, including inpatient care,
4 outpatient care (including audiology, clinical eye
5 and vision care), primary care, secondary and
6 tertiary care, and long term care;

7 “(B) preventive health, including mam-
8 mography and other cancer screening in accord-
9 ance with section 207;

10 “(C) dental care;

11 “(D) mental health, including community
12 mental health services, inpatient mental health
13 services, dormitory mental health services,
14 therapeutic and residential treatment centers,
15 and training of traditional health care practi-
16 tioners;

17 “(E) emergency medical services;

18 “(F) treatment and control of, and reha-
19 bilitative care related to, alcoholism and drug
20 abuse (including fetal alcohol syndrome) among
21 Indians;

22 “(G) accident prevention programs;

23 “(H) home health care;

24 “(I) community health representatives;

25 “(J) maintenance and repair; and

1 “(K) traditional health care practices.

2 “(b) USE OF FUNDS.—

3 “(1) LIMITATION.—Any funds appropriated
4 under the authority of this section shall not be used
5 to offset or limit any other appropriations made to
6 the Service under this Act, the Act of November 2,
7 1921 (25 U.S.C. 13) (commonly known as the ‘Sny-
8 der Act’), or any other provision of law.

9 “(2) ALLOCATION.—

10 “(A) IN GENERAL.—Funds appropriated
11 under the authority of this section shall be allo-
12 cated to service units or Indian tribes or tribal
13 organizations. The funds allocated to each tribe,
14 tribal organization, or service unit under this
15 subparagraph shall be used to improve the
16 health status and reduce the resource deficiency
17 of each tribe served by such service unit, tribe
18 or tribal organization. Such allocation shall
19 weigh the amounts appropriated in favor of
20 those service areas where the health status of
21 Indians within the area, as measured by life ex-
22 pectancy based upon the most recent data avail-
23 able, is significantly lower than the average
24 health status for Indians for all service areas,
25 except that amounts allocated to each such area

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

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

13 “(c) HEALTH STATUS AND RESOURCE DEFICI-
 14 CIENCY.—In this section:

15 “(1) DEFINITION.—The term ‘health status
 16 and resource deficiency’ means the extent to
 17 which—

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

20 “(B) the Indian tribe or tribal organization
 21 does not have available to it the health re-
 22 sources it needs, taking into account the actual
 23 cost of providing health care services given local
 24 geographic, climatic, rural, or other cir-
 25 cumstances.

1 “(2) RESOURCES.—The health resources avail-
2 able to an Indian tribe or tribal organization shall
3 include health resources provided by the Service as
4 well as health resources used by the Indian tribe or
5 tribal organization, including services and financing
6 systems provided by any Federal programs, private
7 insurance, and programs of State or local govern-
8 ments.

9 “(3) REVIEW OF DETERMINATION.—The Sec-
10 retary shall establish procedures which allow any In-
11 dian tribe or tribal organization to petition the Sec-
12 retary for a review of any determination of the ex-
13 tent of the health status and resource deficiency of
14 such tribe or tribal organization.

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

21 “(e) REPORT.—Not later than the date that is 3
22 years after the date of enactment of this Act, the Sec-
23 retary shall submit to the Congress the current health sta-
24 tus and resource deficiency report of the Service for each

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

3 “(1) the methodology then in use by the Service
4 for determining tribal health status and resource de-
5 ficiencies, as well as the most recent application of
6 that methodology;

7 “(2) the extent of the health status and re-
8 source deficiency of each Indian tribe served by the
9 Service;

10 “(3) the amount of funds necessary to eliminate
11 the health status and resource deficiencies of all In-
12 dian tribes served by the Service; and

13 “(4) an estimate of—

14 “(A) the amount of health service funds
15 appropriated under the authority of this Act, or
16 any other Act, including the amount of any
17 funds transferred to the Service, for the preced-
18 ing fiscal year which is allocated to each service
19 unit, Indian tribe, or comparable entity;

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

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

1 to the extent available, information on the wait-
 2 ing lists and number of Indians turned away for
 3 services due to lack of resources.

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

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

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

18 **“SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.**

19 “(a) ESTABLISHMENT.—

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

24 “(A) the amounts deposited under sub-
 25 section (d); and

1 “(B) any amounts appropriated to the
2 CHEF under this Act.

3 “(2) ADMINISTRATION.—The CHEF shall be
4 administered by the Secretary solely for the purpose
5 of meeting the extraordinary medical costs associ-
6 ated with the treatment of victims of disasters or
7 catastrophic illnesses who are within the responsibil-
8 ity of the Service.

9 “(3) EQUITABLE ALLOCATION.—The CHEF
10 shall be equitably allocated, apportioned or delegated
11 on a service unit or area office basis, based upon a
12 formula to be developed by the Secretary in con-
13 sultation with the Indian tribes and tribal organiza-
14 tions through negotiated rulemaking under title
15 VIII. Such formula shall take into account the
16 added needs of service areas which are contract
17 health service dependent.

18 “(4) NOT SUBJECT TO CONTRACT OR GRANT.—
19 No part of the CHEF or its administration shall be
20 subject to contract or grant under any law, including
21 the Indian Self-Determination and Education Assist-
22 ance Act.

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

1 dian tribes and tribal organizations within each serv-
 2 ice area, including a consideration of the needs of
 3 Indian tribes and tribal organizations which are con-
 4 tract health service-dependent.

5 “(b) REQUIREMENTS.—The Secretary shall, through
 6 the negotiated rulemaking process under title VIII, pro-
 7 mulgate regulations consistent with the provisions of this
 8 section—

9 “(1) establish a definition of disasters and cata-
 10 strophic illnesses for which the cost of treatment
 11 provided under contract would qualify for payment
 12 from the CHEF;

13 “(2) provide that a service unit, Indian tribe, or
 14 tribal organization shall not be eligible for reim-
 15 bursement for the cost of treatment from the CHEF
 16 until its cost of treatment for any victim of such a
 17 catastrophic illness or disaster has reached a certain
 18 threshold cost which the Secretary shall establish
 19 at—

20 “(A) for 1999, not less than \$19,000; and

21 “(B) for any subsequent year, not less
 22 than the threshold cost of the previous year in-
 23 creased by the percentage increase in the medi-
 24 cal care expenditure category of the consumer
 25 price index for all urban consumers (United

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

3 “(3) establish a procedure for the reimburse-
4 ment of the portion of the costs incurred by—

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

7 “(B) non-Service facilities or providers
8 whenever otherwise authorized by the Service;

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

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

16 “(5) establish a procedure that will ensure that
17 no payment shall be made from the CHEF to any
18 provider of treatment to the extent that such pro-
19 vider is eligible to receive payment for the treatment
20 from any other Federal, State, local, or private
21 source of reimbursement for which the patient is eli-
22 gible.

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

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

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

“**SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.**

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

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

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

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

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

“(1) DISEASE PREVENTION.—The term ‘disease prevention’ means the reduction, limitation, and pre-

1 vention of disease and its complications, and the re-
 2 duction in the consequences of such diseases,
 3 including—

4 “(A) controlling—

5 “(i) diabetes;

6 “(ii) high blood pressure;

7 “(iii) infectious agents;

8 “(iv) injuries;

9 “(v) occupational hazards and disabil-
 10 ities;

11 “(vi) sexually transmittable diseases;

12 and

13 “(vii) toxic agents; and

14 “(B) providing—

15 “(i) for the fluoridation of water; and

16 “(ii) immunizations.

17 “(2) HEALTH PROMOTION.—The term ‘health
 18 promotion’ means fostering social, economic, envi-
 19 ronmental, and personal factors conducive to health,
 20 including—

21 “(A) raising people’s awareness about
 22 health matters and enabling them to cope with
 23 health problems by increasing their knowledge
 24 and providing them with valid information;

1 “(B) encouraging adequate and appro-
 2 priate diet, exercise, and sleep;

3 “(C) promoting education and work in con-
 4 formity with physical and mental capacity;

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

7 “(E) improving the physical economic, cul-
 8 tural, psychological, and social environment;

9 “(F) promoting adequate opportunity for
 10 spiritual, religious, and traditional practices;
 11 and

12 “(G) adequate and appropriate programs
 13 including—

14 “(i) abuse prevention (mental and
 15 physical);

16 “(ii) community health;

17 “(iii) community safety;

18 “(iv) consumer health education;

19 “(v) diet and nutrition;

20 “(vi) disease prevention (commu-
 21 nicable, immunizations, HIV/AIDS);

22 “(vii) environmental health;

23 “(viii) exercise and physical fitness;

24 “(ix) fetal alcohol disorders;

25 “(x) first aid and CPR education;

- 1 “(xi) human growth and development;
- 2 “(xii) injury prevention and personal
- 3 safety;
- 4 “(xiii) mental health (emotional, self-
- 5 worth);
- 6 “(xiv) personal health and wellness
- 7 practices;
- 8 “(xv) personal capacity building;
- 9 “(xvi) prenatal, pregnancy, and infant
- 10 care;
- 11 “(xvii) psychological well being;
- 12 “(xiii) reproductive health (family
- 13 planning);
- 14 “(xix) safe and adequate water;
- 15 “(xx) safe housing;
- 16 “(xxi) safe work environments;
- 17 “(xxii) stress control;
- 18 “(xxiii) substance abuse;
- 19 “(xxiv) sanitary facilities;
- 20 “(xxv) tobacco use cessation and re-
- 21 duction;
- 22 “(xxvi) violence prevention; and
- 23 “(xxvii) such other activities identified
- 24 by the Service, an Indian tribe or tribal or-

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

3 “(d) EVALUATION.—The Secretary, after obtaining
4 input from affected Indian tribes and tribal organizations,
5 shall submit to the President for inclusion in each state-
6 ment which is required to be submitted to Congress under
7 section 801 an evaluation of—

8 “(1) the health promotion and disease preven-
9 tion needs of Indians;

10 “(2) the health promotion and disease preven-
11 tion activities which would best meet such needs;

12 “(3) the internal capacity of the Service to meet
13 such needs; and

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

18 **“SEC. 204. DIABETES PREVENTION, TREATMENT, AND CON-**
19 **TROL.**

20 “(a) DETERMINATION.—The Secretary, in consulta-
21 tion with Indian tribes and tribal organizations, shall
22 determine—

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

1 of complications resulting from, diabetes among In-
2 dians; and

3 “(2) based on paragraph (1), the measures (in-
4 cluding patient education) each service unit should
5 take to reduce the prevalence of, and prevent, treat,
6 and control the complications resulting from, diabe-
7 tes among Indian tribes within that service unit.

8 “(b) SCREENING.—The Secretary shall screen each
9 Indian who receives services from the Service for diabetes
10 and for conditions which indicate a high risk that the indi-
11 vidual will become diabetic. Such screening may be done
12 by an Indian tribe or tribal organization operating health
13 care programs or facilities with funds from the Service
14 under the Indian Self-Determination and Education As-
15 sistance Act.

16 “(c) CONTINUED FUNDING.—The Secretary shall
17 continue to fund, through fiscal year 2015, each effective
18 model diabetes project in existence on the date of the en-
19 actment of this Act and such other diabetes programs op-
20 erated by the Secretary or by Indian tribes and tribal or-
21 ganizations and any additional programs added to meet
22 existing diabetes needs. Indian tribes and tribal organiza-
23 tions shall receive recurring funding for the diabetes pro-
24 grams which they operate pursuant to this section. Model
25 diabetes projects shall consult, on a regular basis, with

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

3 “(d) DIALYSIS PROGRAMS.—The Secretary shall pro-
4 vide funding through the Service, Indian tribes and tribal
5 organizations to establish dialysis programs, including
6 funds to purchase dialysis equipment and provide nec-
7 essary staffing.

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

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

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

18 “(3) ensure that data collected in each area of-
19 fice regarding diabetes and related complications
20 among Indians is disseminated to tribes, tribal orga-
21 nizations, and all other area offices.

22 **“SEC. 205. SHARED SERVICES.**

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

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

8 “(b) REQUIREMENTS.—A funding agreement or
9 other arrangement entered into pursuant to subsection
10 (a)—

11 “(1) may, at the request of the Indian tribe or
12 tribal organization, delegate to such tribe or tribal
13 organization such powers of supervision and control
14 over Service employees as the Secretary deems nec-
15 essary to carry out the purposes of this section;

16 “(2) shall provide that expenses (including sala-
17 ries) relating to services that are shared between the
18 Service and the tribal facility be allocated propor-
19 tionately between the Service and the tribe or tribal
20 organization; and

21 “(3) may authorize such tribe or tribal organi-
22 zation to construct, renovate, or expand a long-term
23 care or other similar facility (including the construc-
24 tion of a facility attached to a Service facility).

1 “(c) TECHNICAL ASSISTANCE.—The Secretary shall
2 provide such technical and other assistance as may be nec-
3 essary to enable applicants to comply with the provisions
4 of this section.

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

9 **“SEC. 206. HEALTH SERVICES RESEARCH.**

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

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

20 “(c) ELIGIBILITY FOR FUNDS.—Indian tribes and
21 tribal organizations receiving funding from the Service
22 under the authority of the Indian Self-Determination and
23 Education Assistance Act shall be given an equal oppor-
24 tunity to compete for, and receive, research funds under
25 this section.

1 “(d) USE.—Funds received under this section may
2 be used for both clinical and non-clinical research by In-
3 dian tribes and tribal organizations and shall be distrib-
4 uted to the area offices. Such area offices may make
5 grants using such funds within each area.

6 **“SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREEN-**
7 **ING.**

8 “The Secretary, through the Service or through In-
9 dian tribes or tribal organizations, shall provide for the
10 following screening:

11 “(1) Mammography (as defined in section
12 1861(jj) of the Social Security Act) for Indian
13 women at a frequency appropriate to such women
14 under national standards, and under such terms and
15 conditions as are consistent with standards estab-
16 lished by the Secretary to assure the safety and ac-
17 curacy of screening mammography under part B of
18 title XVIII of the Social Security Act.

19 “(2) Other cancer screening meeting national
20 standards.

21 **“SEC. 208. PATIENT TRAVEL COSTS.**

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

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

5 “(1) Emergency air transportation and non-
 6 emergency air transportation where ground trans-
 7 portation is infeasible.

8 “(2) Transportation by private vehicle, specially
 9 equipped vehicle and ambulance.

10 “(3) Transportation by such other means as
 11 may be available and required when air or motor ve-
 12 hicle transportation is not available.

13 **“SEC. 209. EPIDEMIOLOGY CENTERS.**

14 “(a) ESTABLISHMENT.—

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

1 tence may be operated by Indian tribes or tribal or-
 2 ganizations pursuant to funding agreements under
 3 the Indian Self-Determination and Education Assist-
 4 ance Act, but funding under such agreements may
 5 not be divisible.

6 “(2) FUNCTIONS.—In consultation with and
 7 upon the request of Indian tribes, tribal organiza-
 8 tions and urban Indian organizations, each area epi-
 9 demiology center established under this subsection
 10 shall, with respect to such area shall—

11 “(A) collect data related to the health sta-
 12 tus objective described in section 3(b), and
 13 monitor the progress that the Service, Indian
 14 tribes, tribal organizations, and urban Indian
 15 organizations have made in meeting such health
 16 status objective;

17 “(B) evaluate existing delivery systems,
 18 data systems, and other systems that impact
 19 the improvement of Indian health;

20 “(C) assist Indian tribes, tribal organiza-
 21 tions, and urban Indian organizations in identi-
 22 fying their highest priority health status objec-
 23 tives and the services needed to achieve such
 24 objectives, based on epidemiological data;

1 “(D) make recommendations for the tar-
2 geting of services needed by tribal, urban, and
3 other Indian communities;

4 “(E) make recommendations to improve
5 health care delivery systems for Indians and
6 urban Indians;

7 “(F) provide requested technical assistance
8 to Indian tribes and urban Indian organizations
9 in the development of local health service prior-
10 ities and incidence and prevalence rates of dis-
11 ease and other illness in the community; and

12 “(G) provide disease surveillance and assist
13 Indian tribes, tribal organizations, and urban
14 Indian organizations to promote public health.

15 “(3) TECHNICAL ASSISTANCE.—The director of
16 the Centers for Disease Control and Prevention shall
17 provide technical assistance to the centers in carry-
18 ing out the requirements of this subsection.

19 “(b) FUNDING.—The Secretary may make funding
20 available to Indian tribes, tribal organizations, and eligible
21 intertribal consortia or urban Indian organizations to con-
22 duct epidemiological studies of Indian communities.

1 **“SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
2 **PROGRAMS.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Service, shall provide funding to Indian tribes, tribal
5 organizations, and urban Indian organizations to develop
6 comprehensive school health education programs for chil-
7 dren from preschool through grade 12 in schools for the
8 benefit of Indian and urban Indian children.

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

11 “(1) develop and implement health education
12 curricula both for regular school programs and after
13 school programs;

14 “(2) train teachers in comprehensive school
15 health education curricula;

16 “(3) integrate school-based, community-based,
17 and other public and private health promotion ef-
18 forts;

19 “(4) encourage healthy, tobacco-free school en-
20 vironments;

21 “(5) coordinate school-based health programs
22 with existing services and programs available in the
23 community;

24 “(6) develop school programs on nutrition edu-
25 cation, personal health, oral health, and fitness;

26 “(7) develop mental health wellness programs;

1 “(8) develop chronic disease prevention pro-
2 grams;

3 “(9) develop substance abuse prevention pro-
4 grams;

5 “(10) develop injury prevention and safety edu-
6 cation programs;

7 “(11) develop activities for the prevention and
8 control of communicable diseases;

9 “(12) develop community and environmental
10 health education programs that include traditional
11 health care practitioners;

12 “(13) carry out violence prevention activities;
13 and

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

16 “(c) TECHNICAL ASSISTANCE.—The Secretary shall,
17 upon request, provide technical assistance to Indian tribes,
18 tribal organizations and urban Indian organizations in the
19 development of comprehensive health education plans, and
20 the dissemination of comprehensive health education ma-
21 terials and information on existing health programs and
22 resources.

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

1 nizations shall establish criteria for the review and ap-
 2 proval of applications for funding under this section.

3 “(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION
 4 PROGRAM.—

5 “(1) DEVELOPMENT.—The Secretary of the In-
 6 terior, acting through the Bureau of Indian Affairs
 7 and in cooperation with the Secretary and affected
 8 Indian tribes and tribal organizations, shall develop
 9 a comprehensive school health education program for
 10 children from preschool through grade 12 for use in
 11 schools operated by the Bureau of Indian Affairs.

12 “(2) REQUIREMENTS.—The program developed
 13 under paragraph (1) shall include—

14 “(A) school programs on nutrition edu-
 15 cation, personal health, oral health, and fitness;

16 “(B) mental health wellness programs;

17 “(C) chronic disease prevention programs;

18 “(D) substance abuse prevention pro-
 19 grams;

20 “(E) injury prevention and safety edu-
 21 cation programs; and

22 “(F) activities for the prevention and con-
 23 trol of communicable diseases.

24 “(3) TRAINING AND COORDINATION.—The Sec-
 25 retary of the Interior shall—

1 “(A) provide training to teachers in com-
2 prehensive school health education curricula;

3 “(B) ensure the integration and coordina-
4 tion of school-based programs with existing
5 services and health programs available in the
6 community; and

7 “(C) encourage healthy, tobacco-free school
8 environments.

9 **“SEC. 211. INDIAN YOUTH PROGRAM.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Service, is authorized to provide funding to Indian
12 tribes, tribal organizations, and urban Indian organiza-
13 tions for innovative mental and physical disease prevention
14 and health promotion and treatment programs for Indian
15 and urban Indian preadolescent and adolescent youths.

16 “(b) USE OF FUNDS.—

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

19 “(A) develop prevention and treatment
20 programs for Indian youth which promote men-
21 tal and physical health and incorporate cultural
22 values, community and family involvement, and
23 traditional health care practitioners; and

24 “(B) develop and provide community train-
25 ing and education.

1 “(2) LIMITATION.—Funds made available
2 under this section may not be used to provide serv-
3 ices described in section 707(c).

4 “(c) REQUIREMENTS.—The Secretary shall—

5 “(1) disseminate to Indian tribes, tribal organi-
6 zations, and urban Indian organizations information
7 regarding models for the delivery of comprehensive
8 health care services to Indian and urban Indian ado-
9 lescents;

10 “(2) encourage the implementation of such
11 models; and

12 “(3) at the request of an Indian tribe, tribal or-
13 ganization, or urban Indian organization, provide
14 technical assistance in the implementation of such
15 models.

16 “(d) CRITERIA.—The Secretary, in consultation with
17 Indian tribes, tribal organization, and urban Indian orga-
18 nizations, shall establish criteria for the review and ap-
19 proval of applications under this section.

20 **“SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF**
21 **COMMUNICABLE AND INFECTIOUS DISEASES.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Service after consultation with Indian tribes, tribal or-
24 ganizations, urban Indian organizations, and the Centers

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

3 “(1) projects for the prevention, control, and
4 elimination of communicable and infectious diseases,
5 including tuberculosis, hepatitis, HIV, respiratory
6 syncytial virus, hanta virus, sexually transmitted dis-
7 eases, and H. Pylori, which projects may include
8 screening, testing and treatment for HCV and other
9 infectious and communicable diseases;

10 “(2) public information and education programs
11 for the prevention, control, and elimination of com-
12 municable and infectious diseases;

13 “(3) education, training, and clinical skills im-
14 provement activities in the prevention, control, and
15 elimination of communicable and infectious diseases
16 for health professionals, including allied health pro-
17 fessionals; and

18 “(4) a demonstration project that studies the
19 seroprevalence of the Hepatitis C virus among a ran-
20 dom sample of American Indian and Alaskan Native
21 populations and identifies prevalence rates among a
22 variety of tribes and geographic regions.

23 “(b) REQUIREMENT OF APPLICATION.—The Sec-
24 retary may provide funds under subsection (a) only if an
25 application or proposal for such funds is submitted.

1 “(c) TECHNICAL ASSISTANCE AND REPORT.—In car-
2 rying out this section, the Secretary—

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

5 “(2) shall prepare and submit, biennially, a re-
6 port to Congress on the use of funds under this sec-
7 tion and on the progress made toward the preven-
8 tion, control, and elimination of communicable and
9 infectious diseases among Indians and urban Indi-
10 ans.

11 **“SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERV-**
12 **ICES.**

13 “(a) IN GENERAL.—The Secretary, acting through
14 the Service, Indian tribes, and tribal organizations, may
15 provide funding under this Act to meet the objective set
16 forth in section 3 through health care related services and
17 programs not otherwise described in this Act. Such serv-
18 ices and programs shall include services and programs re-
19 lated to—

20 “(1) hospice care and assisted living;

21 “(2) long-term health care;

22 “(3) home- and community-based services;

23 “(4) public health functions; and

24 “(5) traditional health care practices.

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

10 “(c) DEFINITIONS.—In this section:

11 “(1) HOME- AND COMMUNITY-BASED SERV-
 12 ICES.—The term ‘home- and community-based serv-
 13 ices’ means 1 or more of the following:

14 “(A) Homemaker/home health aide serv-
 15 ices.

16 “(B) Chore services.

17 “(C) Personal care services.

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

21 “(E) Training for family members.

22 “(F) Adult day care.

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

1 “(2) HOSPICE CARE.—The term ‘hospice care’
2 means the items and services specified in subpara-
3 graphs (A) through (H) of section 1861(dd)(1) of
4 the Social Security Act (42 U.S.C. 1395x(dd)(1)),
5 and such other services which an Indian tribe or
6 tribal organization determines are necessary and ap-
7 propriate to provide in furtherance of such care.

8 “(3) PUBLIC HEALTH FUNCTIONS.—The term
9 ‘public health functions’ means public health related
10 programs, functions, and services including assess-
11 ments, assurances, and policy development that In-
12 dian tribes and tribal organizations are authorized
13 and encouraged, in those circumstances where it
14 meets their needs, to carry out by forming collabo-
15 rative relationships with all levels of local, State, and
16 Federal governments.

17 **“SEC. 214. INDIAN WOMEN’S HEALTH CARE.**

18 “The Secretary acting through the Service, Indian
19 tribes, tribal organizations, and urban Indian organiza-
20 tions shall provide funding to monitor and improve the
21 quality of health care for Indian women of all ages
22 through the planning and delivery of programs adminis-
23 tered by the Service, in order to improve and enhance the
24 treatment models of care for Indian women.

1 **“SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZ-**
2 **ARDS.**

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

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

21 “(2) an analysis of the potential effect of ongo-
22 ing and future environmental resource development
23 on or near Indian reservations and communities in-
24 cluding the cumulative effect of such development
25 over time on health;

1 “(3) an evaluation of the types and nature of
2 activities, practices, and conditions causing or affect-
3 ing such health problems including uranium mining
4 and milling, uranium mine tailing deposits, nuclear
5 power plant operation and construction, and nuclear
6 waste disposal, oil and gas production or transpor-
7 tation on or near Indian reservations or commu-
8 nities, and other development that could affect the
9 health of Indians and their water supply and food
10 chain;

11 “(4) a summary of any findings or rec-
12 ommendations provided in Federal and State stud-
13 ies, reports, investigations, and inspections during
14 the 5 years prior to the date of the enactment of
15 this Act that directly or indirectly relate to the ac-
16 tivities, practices, and conditions affecting the health
17 or safety of such Indians; and

18 “(5) a description of the efforts that have been
19 made by Federal and State agencies and resource
20 and economic development companies to effectively
21 carry out an education program for such Indians re-
22 garding the health and safety hazards of such devel-
23 opment.

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

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

6 “(1) methods for diagnosing and treating Indi-
7 ans currently exhibiting such health problems;

8 “(2) preventive care and testing for Indians
9 who may be exposed to such health hazards, includ-
10 ing the monitoring of the health of individuals who
11 have or may have been exposed to excessive amounts
12 of radiation, or affected by other activities that have
13 had or could have a serious impact upon the health
14 of such individuals; and

15 “(3) a program of education for Indians who,
16 by reason of their work or geographic proximity to
17 such nuclear or other development activities, may ex-
18 perience health problems.

19 “(c) SUBMISSION TO CONGRESS.—

20 “(1) GENERAL REPORT.—Not later than 18
21 months after the date of enactment of this Act, the
22 Secretary and the Service shall submit to Congress
23 a report concerning the study conducted under sub-
24 section (a).

1 “(2) HEALTH CARE PLAN REPORT.—Not later
 2 than 1 year after the date on which the report under
 3 paragraph (1) is submitted to Congress, the Sec-
 4 retary and the Service shall submit to Congress the
 5 health care plan prepared under subsection (b).
 6 Such plan shall include recommended activities for
 7 the implementation of the plan, as well as an evalua-
 8 tion of any activities previously undertaken by the
 9 Service to address the health problems involved.

10 “(d) TASK FORCE.—

11 “(1) ESTABLISHED.—There is hereby estab-
 12 lished an Intergovernmental Task Force (referred to
 13 in this section as the ‘task force’) that shall be com-
 14 posed of the following individuals (or their des-
 15 ignees):

16 “(A) The Secretary of Energy.

17 “(B) The Administrator of the Environ-
 18 mental Protection Agency.

19 “(C) The Director of the Bureau of Mines.

20 “(D) The Assistant Secretary for Occupa-
 21 tional Safety and Health.

22 “(E) The Secretary of the Interior.

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

1 ards that affect or may affect the health of Indians
 2 on or near an Indian reservation or in an Indian
 3 community, and enter into activities to correct exist-
 4 ing health hazards and ensure that current and fu-
 5 ture health problems resulting from nuclear resource
 6 or other development activities are minimized or re-
 7 duced.

8 “(3) ADMINISTRATIVE PROVISIONS.—The Sec-
 9 retary shall serve as the chairperson of the Task
 10 Force. The Task Force shall meet at least twice
 11 each year. Each member of the Task Force shall
 12 furnish necessary assistance to the Task Force.

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

15 “(1) as a result of employment in or near a
 16 uranium mine or mill or near any other environ-
 17 mental hazard, suffers from a work related illness or
 18 condition;

19 “(2) is eligible to receive diagnosis and treat-
 20 ment services from a Service facility; and

21 “(3) by reason of such Indian’s employment, is
 22 entitled to medical care at the expense of such mine
 23 or mill operator or entity responsible for the environ-
 24 mental hazard;

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

9 **“SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DE-**
 10 **LIVERY AREA.**

11 “(a) IN GENERAL.—For fiscal years beginning with
 12 the fiscal year ending September 30, 1983, and ending
 13 with the fiscal year ending September 30, 2015, the State
 14 of Arizona shall be designated as a contract health service
 15 delivery area by the Service for the purpose of providing
 16 contract health care services to members of federally rec-
 17 ognized Indian tribes of Arizona.

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

1 **“SEC. 216A. NORTH DAKOTA AS A CONTRACT HEALTH**
2 **SERVICE DELIVERY AREA.**

3 “(a) IN GENERAL.—For fiscal years beginning with
4 the fiscal year ending September 30, 2003, and ending
5 with the fiscal year ending September 30, 2015, the State
6 of North Dakota shall be designated as a contract health
7 service delivery area by the Service for the purpose of pro-
8 viding contract health care services to members of feder-
9 ally recognized Indian tribes of North Dakota.

10 “(b) LIMITATION.—The Service shall not curtail any
11 health care services provided to Indians residing on Fed-
12 eral reservations in the State of North Dakota if such cur-
13 tailment is due to the provision of contract services in such
14 State pursuant to the designation of such State as a con-
15 tract health service delivery area pursuant to subsection
16 (a).

17 **“SEC. 216B. SOUTH DAKOTA AS A CONTRACT HEALTH SERV-**
18 **ICE DELIVERY AREA.**

19 “(a) IN GENERAL.—For fiscal years beginning with
20 the fiscal year ending September 30, 2003, and ending
21 with the fiscal year ending September 30, 2015, the State
22 of South Dakota shall be designated as a contract health
23 service delivery area by the Service for the purpose of pro-
24 viding contract health care services to members of feder-
25 ally recognized Indian tribes of South Dakota.

1 “(b) LIMITATION.—The Service shall not curtail any
 2 health care services provided to Indians residing on Fed-
 3 eral reservations in the State of South Dakota if such cur-
 4 tailment is due to the provision of contract services in such
 5 State pursuant to the designation of such State as a con-
 6 tract health service delivery area pursuant to subsection
 7 (a).

8 **“SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEM-**
 9 **ONSTRATION PROGRAM.**

10 “(a) IN GENERAL.—The Secretary may fund a pro-
 11 gram that utilizes the California Rural Indian Health
 12 Board as a contract care intermediary to improve the ac-
 13 cessibility of health services to California Indians.

14 “(b) REIMBURSEMENT OF BOARD.—

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

24 “(2) ADMINISTRATION.—Not more than 5 per-
 25 cent of the amounts provided to the Board under

1 this section for any fiscal year may be used for reim-
2 bursement for administrative expenses incurred by
3 the Board during such fiscal year.

4 “(3) LIMITATION.—No payment may be made
5 for treatment provided under this section to the ex-
6 tent that payment may be made for such treatment
7 under the Catastrophic Health Emergency Fund de-
8 scribed in section 202 or from amounts appropriated
9 or otherwise made available to the California con-
10 tract health service delivery area for a fiscal year.

11 “(c) ADVISORY BOARD.—There is hereby established
12 an advisory board that shall advise the California Rural
13 Indian Health Board in carrying out this section. The ad-
14 visory board shall be composed of representatives, selected
15 by the California Rural Indian Health Board, from not
16 less than 8 tribal health programs serving California Indi-
17 ans covered under this section, at least 50 percent of
18 whom are not affiliated with the California Rural Indian
19 Health Board.

20 **“SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE**
21 **DELIVERY AREA.**

22 “The State of California, excluding the counties of
23 Alameda, Contra Costa, Los Angeles, Marin, Orange, Sac-
24 ramento, San Francisco, San Mateo, Santa Clara, Kern,
25 Merced, Monterey, Napa, San Benito, San Joaquin, San

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

9 **“SEC. 219. CONTRACT HEALTH SERVICES FOR THE TREN-**
 10 **TON SERVICE AREA.**

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

18 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
 19 tion shall be construed as expanding the eligibility of mem-
 20 bers of the Turtle Mountain Band of Chippewa Indians
 21 for health services provided by the Service beyond the
 22 scope of eligibility for such health services that applied on
 23 May 1, 1986.

1 **“SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND**
2 **TRIBAL ORGANIZATIONS.**

3 “The Service shall provide funds for health care pro-
4 grams and facilities operated by Indian tribes and tribal
5 organizations under funding agreements with the Service
6 entered into under the Indian Self-Determination and
7 Education Assistance Act on the same basis as such funds
8 are provided to programs and facilities operated directly
9 by the Service.

10 **“SEC. 221. LICENSING.**

11 “Health care professionals employed by Indian tribes
12 and tribal organizations to carry out agreements under the
13 Indian Self-Determination and Education Assistance Act,
14 shall, if licensed in any State, be exempt from the licensing
15 requirements of the State in which the agreement is per-
16 formed.

17 **“SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT**
18 **HEALTH SERVICES.**

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

1 **“SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.**

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

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

11 “(c) PAYMENT.—The Service shall pay a valid con-
12 tract care service claim within 30 days after the comple-
13 tion of the claim.

14 **“SEC. 224. LIABILITY FOR PAYMENT.**

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

19 “(b) NOTIFICATION.—The Secretary shall notify a
20 contract care provider and any patient who receives con-
21 tract health care services authorized by the Service that
22 such patient is not liable for the payment of any charges
23 or costs associated with the provision of such services.

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

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

3 **“SEC. 225. AUTHORIZATION OF APPROPRIATIONS.**

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

7 **“TITLE III—FACILITIES**

8 **“SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVA-**
 9 **TION OF FACILITIES; REPORTS.**

10 “(a) CONSULTATION.—Prior to the expenditure of, or
 11 the making of any firm commitment to expend, any funds
 12 appropriated for the planning, design, construction, or
 13 renovation of facilities pursuant to the Act of November
 14 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder
 15 Act), the Secretary, acting through the Service, shall—

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

22 “(2) ensure, whenever practicable, that such fa-
 23 cility meets the construction standards of any na-
 24 tionally recognized accrediting body by not later

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

3 “(b) CLOSURE OF FACILITIES.—

4 “(1) IN GENERAL.—Notwithstanding any provi-
5 sion of law other than this subsection, no Service
6 hospital or outpatient health care facility or any in-
7 patient service or special care facility operated by
8 the Service, may be closed if the Secretary has not
9 submitted to the Congress at least 1 year prior to
10 the date such proposed closure an evaluation of the
11 impact of such proposed closure which specifies, in
12 addition to other considerations—

13 “(A) the accessibility of alternative health
14 care resources for the population served by such
15 hospital or facility;

16 “(B) the cost effectiveness of such closure;

17 “(C) the quality of health care to be pro-
18 vided to the population served by such hospital
19 or facility after such closure;

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

22 “(E) the views of the Indian tribes served
23 by such hospital or facility concerning such clo-
24 sure;

1 “(F) the level of utilization of such hos-
2 pital or facility by all eligible Indians; and

3 “(G) the distance between such hospital or
4 facility and the nearest operating Service hos-
5 pital.

6 “(2) TEMPORARY CLOSURE.—Paragraph (1)
7 shall not apply to any temporary closure of a facility
8 or of any portion of a facility if such closure is nec-
9 essary for medical, environmental, or safety reasons.

10 “(c) PRIORITY SYSTEM.—

11 “(1) ESTABLISHMENT.—The Secretary shall es-
12 tablish a health care facility priority system, that
13 shall—

14 “(A) be developed with Indian tribes and
15 tribal organizations through negotiated rule-
16 making under section 802;

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

1 “(C) at a minimum, include the lists re-
 2 quired in paragraph (2)(B) and the methodol-
 3 ogy required in paragraph (2)(E);
 4 except that the priority of any project established
 5 under the construction priority system in effect on
 6 the date of this Act shall not be affected by any
 7 change in the construction priority system taking
 8 place thereafter if the project was identified as one
 9 of the top 10 priority inpatient projects or one of
 10 the top 10 outpatient projects in the Indian Health
 11 Service budget justification for fiscal year 2003, or
 12 if the project had completed both Phase I and Phase
 13 II of the construction priority system in effect on
 14 the date of this Act.

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

19 “(A) a description of the health care facil-
 20 ity priority system of the Service, as established
 21 under paragraph (1);

22 “(B) health care facility lists, including—

23 “(i) the total health care facility plan-
 24 ning, design, construction and renovation
 25 needs for Indians;

1 “(ii) the 10 top-priority inpatient care
2 facilities;

3 “(iii) the 10 top-priority outpatient
4 care facilities;

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

8 “(v) any staff quarters associated
9 with such prioritized facilities;

10 “(C) the justification for the order of pri-
11 ority among facilities;

12 “(D) the projected cost of the projects in-
13 volved; and

14 “(E) the methodology adopted by the Serv-
15 ice in establishing priorities under its health
16 care facility priority system.

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

20 “(A) consult with, and obtain information
21 on all health care facilities needs from, Indian
22 tribes and tribal organizations including those
23 tribes or tribal organizations operating health
24 programs or facilities under any funding agree-
25 ment entered into with the Service under the

1 Indian Self-Determination and Education As-
2 sistance Act; and

3 “(B) review the total unmet needs of all
4 tribes and tribal organizations for health care
5 facilities (including staff quarters), including
6 needs for renovation and expansion of existing
7 facilities.

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

16 “(5) EQUITABLE INTEGRATION.—The Secretary
17 shall ensure that the planning, design, construction,
18 and renovation needs of Service and non-Service fa-
19 cilities, operated under funding agreements in ac-
20 cordance with the Indian Self-Determination and
21 Education Assistance Act are fully and equitably in-
22 tegrated into the health care facility priority system.

23 “(d) REVIEW OF NEED FOR FACILITIES.—

24 “(1) REPORT.—Beginning in 2004, the Sec-
25 retary shall annually submit to the President, for in-

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

8 “(2) CONSULTATION.—In preparing each report
9 required under paragraph (1) (other than the initial
10 report), the Secretary shall consult with Indian
11 tribes and tribal organizations including those tribes
12 or tribal organizations operating health programs or
13 facilities under any funding agreement entered into
14 with the Service under the Indian Self-Determina-
15 tion and Education Assistance Act, and with urban
16 Indian organizations.

17 “(3) CRITERIA.—For purposes of this sub-
18 section, the Secretary shall, in evaluating the needs
19 of facilities operated under any funding agreement
20 entered into with the Service under the Indian Self-
21 Determination and Education Assistance Act, use
22 the same criteria that the Secretary uses in evaluat-
23 ing the needs of facilities operated directly by the
24 Service.

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

8 “(5) ANNUAL NOMINATIONS.—Each year the
9 Secretary shall provide an opportunity for the nomi-
10 nation of planning, design, and construction projects
11 by the Service and all Indian tribes and tribal orga-
12 nizations for consideration under the health care fa-
13 cility priority system.

14 “(e) INCLUSION OF CERTAIN PROGRAMS.—All funds
15 appropriated under the Act of November 2, 1921 (25
16 U.S.C. 13), for the planning, design, construction, or ren-
17 ovation of health facilities for the benefit of an Indian
18 tribe or tribes shall be subject to the provisions of section
19 102 of the Indian Self-Determination and Education As-
20 sistance Act.

21 “(f) INNOVATIVE APPROACHES.—The Secretary shall
22 consult and cooperate with Indian tribes, tribal organiza-
23 tions and urban Indian organizations in developing inno-
24 vative approaches to address all or part of the total unmet
25 need for construction of health facilities, including those

1 provided for in other sections of this title and other ap-
2 proaches.

3 **“SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL**
4 **FACILITIES.**

5 “(a) FINDINGS.—Congress finds and declares that—

6 “(1) the provision of safe water supply facilities
7 and sanitary sewage and solid waste disposal facili-
8 ties is primarily a health consideration and function;

9 “(2) Indian people suffer an inordinately high
10 incidence of disease, injury, and illness directly at-
11 tributable to the absence or inadequacy of such fa-
12 cilities;

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

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

21 “(5) it is in the interest of the United States,
22 and it is the policy of the United States, that all In-
23 dian communities and Indian homes, new and exist-
24 ing, be provided with safe and adequate water sup-

1 ply facilities and sanitary sewage waste disposal fa-
2 cilities as soon as possible.

3 “(b) PROVISION OF FACILITIES AND SERVICES.—

4 “(1) IN GENERAL.—In furtherance of the find-
5 ings and declarations made in subsection (a), Con-
6 gress reaffirms the primary responsibility and au-
7 thority of the Service to provide the necessary sani-
8 tation facilities and services as provided in section 7
9 of the Act of August 5, 1954 (42 U.S.C. 2004a).

10 “(2) ASSISTANCE.—The Secretary, acting
11 through the Service, is authorized to provide under
12 section 7 of the Act of August 5, 1954 (42 U.S.C.
13 2004a)—

14 “(A) financial and technical assistance to
15 Indian tribes, tribal organizations and Indian
16 communities in the establishment, training, and
17 equipping of utility organizations to operate
18 and maintain Indian sanitation facilities, in-
19 cluding the provision of existing plans, standard
20 details, and specifications available in the De-
21 partment, to be used at the option of the tribe
22 or tribal organization;

23 “(B) ongoing technical assistance and
24 training in the management of utility organiza-

1 tions which operate and maintain sanitation fa-
2 cilities; and

3 “(C) priority funding for the operation,
4 and maintenance assistance for, and emergency
5 repairs to, tribal sanitation facilities when nec-
6 essary to avoid an imminent health threat or to
7 protect the investment in sanitation facilities
8 and the investment in the health benefits
9 gained through the provision of sanitation fa-
10 cilities.

11 “(3) PROVISIONS RELATING TO FUNDING.—
12 Notwithstanding any other provision of law—

13 “(A) the Secretary of Housing and Urban
14 Development is authorized to transfer funds ap-
15 propriated under the Native American Housing
16 Assistance and Self-Determination Act of 1996
17 to the Secretary of Health and Human Serv-
18 ices;

19 “(B) the Secretary of Health and Human
20 Services is authorized to accept and use such
21 funds for the purpose of providing sanitation
22 facilities and services for Indians under section
23 7 of the Act of August 5, 1954 (42 U.S.C.
24 2004a);

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

9 “(D) the Secretary of Health and Human
10 Services is authorized to accept all Federal
11 funds that are available for the purpose of pro-
12 viding sanitation facilities and related services
13 and place those funds into funding agreements,
14 authorized under the Indian Self-Determination
15 and Education Assistance Act, between the Sec-
16 retary and Indian tribes and tribal organiza-
17 tions;

18 “(E) the Secretary may permit funds ap-
19 propriated under the authority of section 4 of
20 the Act of August 5, 1954 (42 U.S.C. 2004) to
21 be used to fund up to 100 percent of the
22 amount of a tribe’s loan obtained under any
23 Federal program for new projects to construct
24 eligible sanitation facilities to serve Indian
25 homes;

1 “(F) the Secretary may permit funds ap-
2 propriated under the authority of section 4 of
3 the Act of August 5, 1954 (42 U.S.C. 2004) to
4 be used to meet matching or cost participation
5 requirements under other Federal and non-Fed-
6 eral programs for new projects to construct eli-
7 gible sanitation facilities;

8 “(G) all Federal agencies are authorized to
9 transfer to the Secretary funds identified,
10 granted, loaned or appropriated and thereafter
11 the Department’s applicable policies, rules, reg-
12 ulations shall apply in the implementation of
13 such projects;

14 “(H) the Secretary of Health and Human
15 Services shall enter into inter-agency agree-
16 ments with the Bureau of Indian Affairs, the
17 Department of Housing and Urban Develop-
18 ment, the Department of Agriculture, the Envi-
19 ronmental Protection Agency and other appro-
20 priate Federal agencies, for the purpose of pro-
21 viding financial assistance for safe water supply
22 and sanitary sewage disposal facilities under
23 this Act; and

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

1 rulemaking under section 802, establish stand-
2 ards applicable to the planning, design and con-
3 struction of water supply and sanitary sewage
4 and solid waste disposal facilities funded under
5 this Act.

6 “(c) 10-YEAR FUNDING PLAN.—The Secretary, act-
7 ing through the Service and in consultation with Indian
8 tribes and tribal organizations, shall develop and imple-
9 ment a 10-year funding plan to provide safe water supply
10 and sanitary sewage and solid waste disposal facilities
11 serving existing Indian homes and communities, and to
12 new and renovated Indian homes.

13 “(d) CAPABILITY OF TRIBE OR COMMUNITY.—The
14 financial and technical capability of an Indian tribe or
15 community to safely operate and maintain a sanitation fa-
16 cility shall not be a prerequisite to the provision or con-
17 struction of sanitation facilities by the Secretary.

18 “(e) FINANCIAL ASSISTANCE.—The Secretary may
19 provide financial assistance to Indian tribes, tribal organi-
20 zations and communities for the operation, management,
21 and maintenance of their sanitation facilities.

22 “(f) RESPONSIBILITY FOR FEES FOR OPERATION
23 AND MAINTENANCE.—The Indian family, community or
24 tribe involved shall have the primary responsibility to es-
25 tablish, collect, and use reasonable user fees, or otherwise

1 set aside funding, for the purpose of operating and main-
2 taining sanitation facilities. If a community facility is
3 threatened with imminent failure and there is a lack of
4 tribal capacity to maintain the integrity or the health ben-
5 efit of the facility, the Secretary may assist the tribe in
6 the resolution of the problem on a short term basis
7 through cooperation with the emergency coordinator or by
8 providing operation and maintenance service.

9 “(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANI-
10 ZATIONS.—Programs administered by Indian tribes or
11 tribal organizations under the authority of the Indian Self-
12 Determination and Education Assistance Act shall be eli-
13 gible for—

14 “(1) any funds appropriated pursuant to this
15 section; and

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

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

21 “(h) REPORT.—

22 “(1) IN GENERAL.—The Secretary shall submit
23 to the President, for inclusion in each report re-
24 quired to be transmitted to the Congress under sec-
25 tion 801, a report which sets forth—

1 “(A) the current Indian sanitation facility
2 priority system of the Service;

3 “(B) the methodology for determining
4 sanitation deficiencies;

5 “(C) the level of initial and final sanitation
6 deficiency for each type sanitation facility for
7 each project of each Indian tribe or community;
8 and

9 “(D) the amount of funds necessary to re-
10 duce the identified sanitation deficiency levels of
11 all Indian tribes and communities to a level I
12 sanitation deficiency as described in paragraph
13 (4)(A).

14 “(2) CONSULTATION.—In preparing each report
15 required under paragraph (1), the Secretary shall
16 consult with Indian tribes and tribal organizations
17 (including those tribes or tribal organizations operat-
18 ing health care programs or facilities under any
19 funding agreements entered into with the Service
20 under the Indian Self-Determination and Education
21 Assistance Act) to determine the sanitation needs of
22 each tribe and in developing the criteria on which
23 the needs will be evaluated through a process of ne-
24 gotiated rulemaking.

1 “(3) METHODOLOGY.—The methodology used
2 by the Secretary in determining, preparing cost esti-
3 mates for and reporting sanitation deficiencies for
4 purposes of paragraph (1) shall be applied uniformly
5 to all Indian tribes and communities.

6 “(4) SANITATION DEFICIENCY LEVELS.—For
7 purposes of this subsection, the sanitation deficiency
8 levels for an individual or community sanitation fa-
9 cility serving Indian homes are as follows:

10 “(A) A level I deficiency is a sanitation fa-
11 cility serving an individual or community—

12 “(i) which complies with all applicable
13 water supply, pollution control and solid
14 waste disposal laws; and

15 “(ii) in which the deficiencies relate to
16 routine replacement, repair, or mainte-
17 nance needs.

18 “(B) A level II deficiency is a sanitation
19 facility serving an individual or community—

20 “(i) which substantially or recently
21 complied with all applicable water supply,
22 pollution control and solid waste laws, in
23 which the deficiencies relate to small or
24 minor capital improvements needed to
25 bring the facility back into compliance;

1 “(ii) in which the deficiencies relate to
 2 capital improvements that are necessary to
 3 enlarge or improve the facilities in order to
 4 meet the current needs for domestic sani-
 5 tation facilities; or

6 “(iii) in which the deficiencies relate
 7 to the lack of equipment or training by an
 8 Indian tribe or community to properly op-
 9 erate and maintain the sanitation facilities.

10 “(C) A level III deficiency is an individual
 11 or community facility with water or sewer serv-
 12 ice in the home, piped services or a haul system
 13 with holding tanks and interior plumbing, or
 14 where major significant interruptions to water
 15 supply or sewage disposal occur frequently, re-
 16 quiring major capital improvements to correct
 17 the deficiencies. There is no access to or no ap-
 18 proved or permitted solid waste facility avail-
 19 able.

20 “(D) A level IV deficiency is an individual
 21 or community facility where there are no piped
 22 water or sewer facilities in the home or the fa-
 23 cility has become inoperable due to major com-
 24 ponent failure or where only a washeteria or
 25 central facility exists.

1 “(E) A level V deficiency is the absence of
 2 a sanitation facility, where individual homes do
 3 not have access to safe drinking water or ade-
 4 quate wastewater disposal.

5 “(i) DEFINITIONS.—In this section:

6 “(1) FACILITY.—The terms ‘facility’ or ‘facili-
 7 ties’ shall have the same meaning as the terms ‘sys-
 8 tem’ or ‘systems’ unless the context requires other-
 9 wise.

10 “(2) INDIAN COMMUNITY.—The term ‘Indian
 11 community’ means a geographic area, a significant
 12 proportion of whose inhabitants are Indians and
 13 which is served by or capable of being served by a
 14 facility described in this section.

15 **“SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.**

16 “(a) IN GENERAL.—The Secretary, acting through
 17 the Service, may utilize the negotiating authority of the
 18 Act of June 25, 1910 (25 U.S.C. 47), to give preference
 19 to any Indian or any enterprise, partnership, corporation,
 20 or other type of business organization owned and con-
 21 trolled by an Indian or Indians including former or cur-
 22 rently federally recognized Indian tribes in the State of
 23 New York (hereinafter referred to as an ‘Indian firm’) in
 24 the construction and renovation of Service facilities pursu-
 25 ant to section 301 and in the construction of safe water

1 and sanitary waste disposal facilities pursuant to section
 2 302. Such preference may be accorded by the Secretary
 3 unless the Secretary finds, pursuant to rules and regula-
 4 tions promulgated by the Secretary, that the project or
 5 function to be contracted for will not be satisfactory or
 6 such project or function cannot be properly completed or
 7 maintained under the proposed contract. The Secretary,
 8 in arriving at such finding, shall consider whether the In-
 9 dian or Indian firm will be deficient with respect to—

- 10 “(1) ownership and control by Indians;
- 11 “(2) equipment;
- 12 “(3) bookkeeping and accounting procedures;
- 13 “(4) substantive knowledge of the project or
- 14 function to be contracted for;
- 15 “(5) adequately trained personnel; or
- 16 “(6) other necessary components of contract
- 17 performance.

18 “(b) EXEMPTION FROM DAVIS-BACON.—For the
 19 purpose of implementing the provisions of this title, con-
 20 struction or renovation of facilities constructed or ren-
 21 ovated in whole or in part by funds made available pursu-
 22 ant to this title are exempt from the Act of March 3, 1931
 23 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon
 24 Act). For all health facilities, staff quarters and sanitation
 25 facilities, construction and renovation subcontractors shall

1 be paid wages at rates that are not less than the prevailing
 2 wage rates for similar construction in the locality involved,
 3 as determined by the Indian tribe, tribes, or tribal organi-
 4 zations served by such facilities.

5 **“SEC. 304. SOBOBA SANITATION FACILITIES.**

6 “Nothing in the Act of December 17, 1970 (84 Stat.
 7 1465) shall be construed to preclude the Soboba Band of
 8 Mission Indians and the Soboba Indian Reservation from
 9 being provided with sanitation facilities and services under
 10 the authority of section 7 of the Act of August 5, 1954
 11 (68 Stat. 674), as amended by the Act of July 31, 1959
 12 (73 Stat. 267).

13 **“SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR REN-**
 14 **OVATION.**

15 “(a) PERMISSIBILITY.—

16 “(1) IN GENERAL.—Notwithstanding any other
 17 provision of law, the Secretary is authorized to ac-
 18 cept any major expansion, renovation or moderniza-
 19 tion by any Indian tribe of any Service facility, or
 20 of any other Indian health facility operated pursuant
 21 to a funding agreement entered into under the In-
 22 dian Self-Determination and Education Assistance
 23 Act, including—

24 “(A) any plans or designs for such expan-
 25 sion, renovation or modernization; and

1 “(B) any expansion, renovation or mod-
 2 ernization for which funds appropriated under
 3 any Federal law were lawfully expended;
 4 but only if the requirements of subsection (b) are
 5 met.

6 “(2) PRIORITY LIST.—The Secretary shall
 7 maintain a separate priority list to address the need
 8 for increased operating expenses, personnel or equip-
 9 ment for such facilities described in paragraph (1).
 10 The methodology for establishing priorities shall be
 11 developed by negotiated rulemaking under section
 12 802. The list of priority facilities will be revised an-
 13 nually in consultation with Indian tribes and tribal
 14 organizations.

15 “(3) REPORT.—The Secretary shall submit to
 16 the President, for inclusion in each report required
 17 to be transmitted to the Congress under section 801,
 18 the priority list maintained pursuant to paragraph
 19 (2).

20 “(b) REQUIREMENTS.—The requirements of this sub-
 21 section are met with respect to any expansion, renovation
 22 or modernization if—

23 “(1) the tribe or tribal organization—

24 “(A) provides notice to the Secretary of its
 25 intent to expand, renovate or modernize; and

1 “(B) applies to the Secretary to be placed
 2 on a separate priority list to address the needs
 3 of such new facilities for increased operating ex-
 4 penses, personnel or equipment; and

5 “(2) the expansion renovation or
 6 modernization—

7 “(A) is approved by the appropriate area
 8 director of the Service for Federal facilities; and

9 “(B) is administered by the Indian tribe or
 10 tribal organization in accordance with any ap-
 11 plicable regulations prescribed by the Secretary
 12 with respect to construction or renovation of
 13 Service facilities.

14 “(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FA-
 15 CILITY TO BE USED AS A SERVICE FACILITY.—If any
 16 Service facility which has been expanded, renovated or
 17 modernized by an Indian tribe under this section ceases
 18 to be used as a Service facility during the 20-year period
 19 beginning on the date such expansion, renovation or mod-
 20 ernization is completed, such Indian tribe shall be entitled
 21 to recover from the United States an amount which bears
 22 the same ratio to the value of such facility at the time
 23 of such cessation as the value of such expansion, renova-
 24 tion or modernization (less the total amount of any funds
 25 provided specifically for such facility under any Federal

1 program that were expended for such expansion, renova-
 2 tion or modernization) bore to the value of such facility
 3 at the time of the completion of such expansion, renova-
 4 tion or modernization.

5 **“SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION,**
 6 **AND MODERNIZATION OF SMALL AMBULA-**
 7 **TORY CARE FACILITIES.**

8 “(a) AVAILABILITY OF FUNDING.—

9 “(1) IN GENERAL.—The Secretary, acting
 10 through the Service and in consultation with Indian
 11 tribes and tribal organization, shall make funding
 12 available to tribes and tribal organizations for the
 13 construction, expansion, or modernization of facili-
 14 ties for the provision of ambulatory care services to
 15 eligible Indians (and noneligible persons as provided
 16 for in subsections (b)(2) and (c)(1)(C)). Funding
 17 under this section may cover up to 100 percent of
 18 the costs of such construction, expansion, or mod-
 19 ernization. For the purposes of this section, the term
 20 ‘construction’ includes the replacement of an exist-
 21 ing facility.

22 “(2) REQUIREMENT.—Funding under para-
 23 graph (1) may only be made available to an Indian
 24 tribe or tribal organization operating an Indian
 25 health facility (other than a facility owned or con-

1 structed by the Service, including a facility originally
2 owned or constructed by the Service and transferred
3 to an Indian tribe or tribal organization) pursuant
4 to a funding agreement entered into under the In-
5 dian Self-Determination and Education Assistance
6 Act.

7 “(b) USE OF FUNDS.—

8 “(1) IN GENERAL.—Funds provided under this
9 section may be used only for the construction, ex-
10 pansion, or modernization (including the planning
11 and design of such construction, expansion, or mod-
12 ernization) of an ambulatory care facility—

13 “(A) located apart from a hospital;

14 “(B) not funded under section 301 or sec-
15 tion 307; and

16 “(C) which, upon completion of such con-
17 struction, expansion, or modernization will—

18 “(i) have a total capacity appropriate
19 to its projected service population;

20 “(ii) provide annually not less than
21 500 patient visits by eligible Indians and
22 other users who are eligible for services in
23 such facility in accordance with section
24 807(b)(1)(B); and

1 “(iii) provide ambulatory care in a
2 service area (specified in the funding
3 agreement entered into under the Indian
4 Self-Determination and Education Assist-
5 ance Act) with a population of not less
6 than 1,500 eligible Indians and other users
7 who are eligible for services in such facility
8 in accordance with section 807(b)(1)(B).

9 “(2) LIMITATION.—Funding provided under
10 this section may be used only for the cost of that
11 portion of a construction, expansion or moderniza-
12 tion project that benefits the service population de-
13 scribed in clauses (ii) and (iii) of paragraph (1)(C).
14 The requirements of such clauses (ii) and (iii) shall
15 not apply to a tribe or tribal organization applying
16 for funding under this section whose principal office
17 for health care administration is located on an island
18 or where such office is not located on a road system
19 providing direct access to an inpatient hospital
20 where care is available to the service population.

21 “(c) APPLICATION AND PRIORITY.—

22 “(1) APPLICATION.—No funding may be made
23 available under this section unless an application for
24 such funding has been submitted to and approved by
25 the Secretary. An application or proposal for fund-

1 ing under this section shall be submitted in accord-
2 ance with applicable regulations and shall set forth
3 reasonable assurance by the applicant that, at all
4 times after the construction, expansion, or mod-
5 ernization of a facility carried out pursuant to fund-
6 ing received under this section—

7 “(A) adequate financial support will be
8 available for the provision of services at such
9 facility;

10 “(B) such facility will be available to eligi-
11 ble Indians without regard to ability to pay or
12 source of payment; and

13 “(C) such facility will, as feasible without
14 diminishing the quality or quantity of services
15 provided to eligible Indians, serve noneligible
16 persons on a cost basis.

17 “(2) PRIORITY.—In awarding funds under this
18 section, the Secretary shall give priority to tribes
19 and tribal organizations that demonstrate—

20 “(A) a need for increased ambulatory care
21 services; and

22 “(B) insufficient capacity to deliver such
23 services.

24 “(d) FAILURE TO USE FACILITY AS HEALTH FACIL-
25 ITY.—If any facility (or portion thereof) with respect to

1 which funds have been paid under this section, ceases,
2 within 5 years after completion of the construction, expan-
3 sion, or modernization carried out with such funds, to be
4 utilized for the purposes of providing health care services
5 to eligible Indians, all of the right, title, and interest in
6 and to such facility (or portion thereof) shall transfer to
7 the United States unless otherwise negotiated by the Serv-
8 ice and the Indian tribe or tribal organization.

9 “(e) NO INCLUSION IN TRIBAL SHARE.—Funding
10 provided to Indian tribes and tribal organizations under
11 this section shall be non-recurring and shall not be avail-
12 able for inclusion in any individual tribe’s tribal share for
13 an award under the Indian Self-Determination and Edu-
14 cation Assistance Act or for reallocation or redesign there-
15 under.

16 **“SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.**
17

18 “(a) HEALTH CARE DELIVERY DEMONSTRATION
19 PROJECTS.—The Secretary, acting through the Service
20 and in consultation with Indian tribes and tribal organiza-
21 tions, may enter into funding agreements with, or make
22 grants or loan guarantees to, Indian tribes or tribal orga-
23 nizations for the purpose of carrying out a health care de-
24 livery demonstration project to test alternative means of
25 delivering health care and services through health facili-

1 ties, including hospice, traditional Indian health and child
2 care facilities, to Indians.

3 “(b) USE OF FUNDS.—The Secretary, in approving
4 projects pursuant to this section, may authorize funding
5 for the construction and renovation of hospitals, health
6 centers, health stations, and other facilities to deliver
7 health care services and is authorized to—

8 “(1) waive any leasing prohibition;

9 “(2) permit carryover of funds appropriated for
10 the provision of health care services;

11 “(3) permit the use of other available funds;

12 “(4) permit the use of funds or property do-
13 nated from any source for project purposes;

14 “(5) provide for the reversion of donated real or
15 personal property to the donor; and

16 “(6) permit the use of Service funds to match
17 other funds, including Federal funds.

18 “(c) CRITERIA.—

19 “(1) IN GENERAL.—The Secretary shall develop
20 and publish regulations through rulemaking under
21 section 802 for the review and approval of applica-
22 tions submitted under this section. The Secretary
23 may enter into a contract, funding agreement or
24 award a grant under this section for projects which
25 meet the following criteria:

1 “(A) There is a need for a new facility or
2 program or the reorientation of an existing fa-
3 cility or program.

4 “(B) A significant number of Indians, in-
5 cluding those with low health status, will be
6 served by the project.

7 “(C) The project has the potential to ad-
8 dress the health needs of Indians in an innova-
9 tive manner.

10 “(D) The project has the potential to de-
11 liver services in an efficient and effective man-
12 ner.

13 “(E) The project is economically viable.

14 “(F) The Indian tribe or tribal organiza-
15 tion has the administrative and financial capa-
16 bility to administer the project.

17 “(G) The project is integrated with provid-
18 ers of related health and social services and is
19 coordinated with, and avoids duplication of, ex-
20 isting services.

21 “(2) PEER REVIEW PANELS.—The Secretary
22 may provide for the establishment of peer review
23 panels, as necessary, to review and evaluate applica-
24 tions and to advise the Secretary regarding such ap-

1 plications using the criteria developed pursuant to
2 paragraph (1).

3 “(3) PRIORITY.—The Secretary shall give prior-
4 ity to applications for demonstration projects under
5 this section in each of the following service units to
6 the extent that such applications are filed in a time-
7 ly manner and otherwise meet the criteria specified
8 in paragraph (1):

9 “(A) Cass Lake, Minnesota.

10 “(B) Clinton, Oklahoma.

11 “(C) Harlem, Montana.

12 “(D) Mescalero, New Mexico.

13 “(E) Owyhee, Nevada.

14 “(F) Parker, Arizona.

15 “(G) Schurz, Nevada.

16 “(H) Winnebago, Nebraska.

17 “(I) Ft. Yuma, California.

18 “(d) TECHNICAL ASSISTANCE.—The Secretary shall
19 provide such technical and other assistance as may be nec-
20 essary to enable applicants to comply with the provisions
21 of this section.

22 “(e) SERVICE TO INELIGIBLE PERSONS.—The au-
23 thority to provide services to persons otherwise ineligible
24 for the health care benefits of the Service and the author-
25 ity to extend hospital privileges in Service facilities to non-

1 Service health care practitioners as provided in section
2 807 may be included, subject to the terms of such section,
3 in any demonstration project approved pursuant to this
4 section.

5 “(f) EQUITABLE TREATMENT.—For purposes of sub-
6 section (c)(1)(A), the Secretary shall, in evaluating facili-
7 ties operated under any funding agreement entered into
8 with the Service under the Indian Self-Determination and
9 Education Assistance Act, use the same criteria that the
10 Secretary uses in evaluating facilities operated directly by
11 the Service.

12 “(g) EQUITABLE INTEGRATION OF FACILITIES.—
13 The Secretary shall ensure that the planning, design, con-
14 struction, renovation and expansion needs of Service and
15 non-Service facilities which are the subject of a funding
16 agreement for health services entered into with the Service
17 under the Indian Self-Determination and Education As-
18 sistance Act, are fully and equitably integrated into the
19 implementation of the health care delivery demonstration
20 projects under this section.

21 **“SEC. 308. LAND TRANSFER.**

22 “(a) GENERAL AUTHORITY FOR TRANSFERS.—Not-
23 withstanding any other provision of law, the Bureau of
24 Indian Affairs and all other agencies and departments of
25 the United States are authorized to transfer, at no cost,

1 land and improvements to the Service for the provision
2 of health care services. The Secretary is authorized to ac-
3 cept such land and improvements for such purposes.

4 “(b) CHEMAWA INDIAN SCHOOL.—The Bureau of In-
5 dian Affairs is authorized to transfer, at no cost, up to
6 5 acres of land at the Chemawa Indian School, Salem,
7 Oregon, to the Service for the provision of health care
8 services. The land authorized to be transferred by this sec-
9 tion is that land adjacent to land under the jurisdiction
10 of the Service and occupied by the Chemawa Indian
11 Health Center.

12 **“SEC. 309. LEASES.**

13 “(a) IN GENERAL.—Notwithstanding any other pro-
14 vision of law, the Secretary is authorized, in carrying out
15 the purposes of this Act, to enter into leases with Indian
16 tribes and tribal organizations for periods not in excess
17 of 20 years. Property leased by the Secretary from an In-
18 dian tribe or tribal organization may be reconstructed or
19 renovated by the Secretary pursuant to an agreement with
20 such Indian tribe or tribal organization.

21 “(b) FACILITIES FOR THE ADMINISTRATION AND DE-
22 LIVERY OF HEALTH SERVICES.—The Secretary may enter
23 into leases, contracts, and other legal agreements with In-
24 dian tribes or tribal organizations which hold—

25 “(1) title to;

1 “(2) a leasehold interest in; or

2 “(3) a beneficial interest in (where title is held
3 by the United States in trust for the benefit of a
4 tribe);

5 facilities used for the administration and delivery of health
6 services by the Service or by programs operated by Indian
7 tribes or tribal organizations to compensate such Indian
8 tribes or tribal organizations for costs associated with the
9 use of such facilities for such purposes, and such leases
10 shall be considered as operating leases for the purposes
11 of scoring under the Budget Enforcement Act, notwith-
12 standing any other provision of law. Such costs include
13 rent, depreciation based on the useful life of the building,
14 principal and interest paid or accrued, operation and
15 maintenance expenses, and other expenses determined by
16 regulation to be allowable pursuant to regulations under
17 section 105(l) of the Indian Self-Determination and Edu-
18 cation Assistance Act.

19 **“SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAY-**
20 **MENT.**

21 “(a) HEALTH CARE FACILITIES LOAN FUND.—
22 There is established in the Treasury of the United States
23 a fund to be known as the ‘Health Care Facilities Loan
24 Fund’ (referred to in this Act as the ‘HCFLF’) to provide
25 to Indian tribes and tribal organizations direct loans, or

1 guarantees for loans, for the construction of health care
2 facilities (including inpatient facilities, outpatient facili-
3 ties, associated staff quarters and specialized care facili-
4 ties such as behavioral health and elder care facilities).

5 “(b) STANDARDS AND PROCEDURES.—The Secretary
6 may promulgate regulations, developed through rule-
7 making as provided for in section 802, to establish stand-
8 ards and procedures for governing loans and loan guaran-
9 tees under this section, subject to the following conditions:

10 “(1) The principal amount of a loan or loan
11 guarantee may cover up to 100 percent of eligible
12 costs, including costs for the planning, design, fi-
13 nancing, site land development, construction, reha-
14 bilitation, renovation, conversion, improvements,
15 medical equipment and furnishings, other facility re-
16 lated costs and capital purchase (but excluding staff-
17 ing).

18 “(2) The cumulative total of the principal of di-
19 rect loans and loan guarantees, respectively, out-
20 standing at any one time shall not exceed such limi-
21 tations as may be specified in appropriation Acts.

22 “(3) In the discretion of the Secretary, the pro-
23 gram under this section may be administered by the
24 Service or the Health Resources and Services Ad-
25 ministration (which shall be specified by regulation).

1 “(4) The Secretary may make or guarantee a
2 loan with a term of the useful estimated life of the
3 facility, or 25 years, whichever is less.

4 “(5) The Secretary may allocate up to 100 per-
5 cent of the funds available for loans or loan guaran-
6 tees in any year for the purpose of planning and ap-
7 plying for a loan or loan guarantee.

8 “(6) The Secretary may accept an assignment
9 of the revenue of an Indian tribe or tribal organiza-
10 tion as security for any direct loan or loan guarantee
11 under this section.

12 “(7) In the planning and design of health facili-
13 ties under this section, users eligible under section
14 807(b) may be included in any projection of patient
15 population.

16 “(8) The Secretary shall not collect loan appli-
17 cation, processing or other similar fees from Indian
18 tribes or tribal organizations applying for direct
19 loans or loan guarantees under this section.

20 “(9) Service funds authorized under loans or
21 loan guarantees under this section may be used in
22 matching other Federal funds.

23 “(c) FUNDING.—

24 “(1) IN GENERAL.—The HCFLF shall consist
25 of—

1 “(A) such sums as may be initially appro-
 2 priated to the HCFLF and as may be subse-
 3 quently appropriated under paragraph (2);

4 “(B) such amounts as may be collected
 5 from borrowers; and

6 “(C) all interest earned on amounts in the
 7 HCFLF.

8 “(2) AUTHORIZATION OF APPROPRIATIONS.—

9 There is authorized to be appropriated such sums as
 10 may be necessary to initiate the HCFLF. For each
 11 fiscal year after the initial year in which funds are
 12 appropriated to the HCFLF, there is authorized to
 13 be appropriated an amount equal to the sum of the
 14 amount collected by the HCFLF during the preced-
 15 ing fiscal year, and all accrued interest on such
 16 amounts.

17 “(3) AVAILABILITY OF FUNDS.—Amounts ap-
 18 propriated, collected or earned relative to the
 19 HCFLF shall remain available until expended.

20 “(d) FUNDING AGREEMENTS.—Amounts in the
 21 HCFLF and available pursuant to appropriation Acts may
 22 be expended by the Secretary, acting through the Service,
 23 to make loans under this section to an Indian tribe or trib-
 24 al organization pursuant to a funding agreement entered

1 into under the Indian Self-Determination and Education
2 Assistance Act.

3 “(e) INVESTMENTS.—The Secretary of the Treasury
4 shall invest such amounts of the HCFLF as such Sec-
5 retary determines are not required to meet current with-
6 drawals from the HCFLF. Such investments may be made
7 only in interest-bearing obligations of the United States.
8 For such purpose, such obligations may be acquired on
9 original issue at the issue price, or by purchase of out-
10 standing obligations at the market price. Any obligation
11 acquired by the fund may be sold by the Secretary of the
12 Treasury at the market price.

13 “(f) GRANTS.—The Secretary is authorized to estab-
14 lish a program to provide grants to Indian tribes and trib-
15 al organizations for the purpose of repaying all or part
16 of any loan obtained by an Indian tribe or tribal organiza-
17 tion for construction and renovation of health care facili-
18 ties (including inpatient facilities, outpatient facilities, as-
19 sociated staff quarters and specialized care facilities).
20 Loans eligible for such repayment grants shall include
21 loans that have been obtained under this section or other-
22 wise.

23 **“SEC. 311. TRIBAL LEASING.**

24 “Indian tribes and tribal organizations providing
25 health care services pursuant to a funding agreement con-

1 tract entered into under the Indian Self-Determination
 2 and Education Assistance Act may lease permanent struc-
 3 tures for the purpose of providing such health care serv-
 4 ices without obtaining advance approval in appropriation
 5 Acts.

6 **“SEC. 312. INDIAN HEALTH SERVICE/TRIBAL FACILITIES**
 7 **JOINT VENTURE PROGRAM.**

8 “(a) AUTHORITY.—

9 “(1) IN GENERAL.—The Secretary, acting
 10 through the Service, shall make arrangements with
 11 Indian tribes and tribal organizations to establish
 12 joint venture demonstration projects under which an
 13 Indian tribe or tribal organization shall expend trib-
 14 al, private, or other available funds, for the acquisi-
 15 tion or construction of a health facility for a mini-
 16 mum of 10 years, under a no-cost lease, in exchange
 17 for agreement by the Service to provide the equip-
 18 ment, supplies, and staffing for the operation and
 19 maintenance of such a health facility.

20 “(2) USE OF RESOURCES.—A tribe or tribal or-
 21 ganization may utilize tribal funds, private sector, or
 22 other available resources, including loan guarantees,
 23 to fulfill its commitment under this subsection.

24 “(3) ELIGIBILITY OF CERTAIN ENTITIES.—A
 25 tribe that has begun and substantially completed the

1 process of acquisition or construction of a health fa-
 2 cility shall be eligible to establish a joint venture
 3 project with the Service using such health facility.

4 “(b) REQUIREMENTS.—

5 “(1) IN GENERAL.—The Secretary shall enter
 6 into an arrangement under subsection (a)(1) with an
 7 Indian tribe or tribal organization only if—

8 “(A) the Secretary first determines that
 9 the Indian tribe or tribal organization has the
 10 administrative and financial capabilities nec-
 11 essary to complete the timely acquisition or con-
 12 struction of the health facility described in sub-
 13 section (a)(1); and

14 “(B) the Indian tribe or tribal organization
 15 meets the needs criteria that shall be developed
 16 through the negotiated rulemaking process pro-
 17 vided for under section 802.

18 “(2) CONTINUED OPERATION OF FACILITY.—
 19 The Secretary shall negotiate an agreement with the
 20 Indian tribe or tribal organization regarding the con-
 21 tinued operation of a facility under this section at
 22 the end of the initial 10 year no-cost lease period.

23 “(3) BREACH OR TERMINATION OF AGREE-
 24 MENT.—An Indian tribe or tribal organization that
 25 has entered into a written agreement with the Sec-

1 retary under this section, and that breaches or ter-
2 minates without cause such agreement, shall be lia-
3 ble to the United States for the amount that has
4 been paid to the tribe or tribal organization, or paid
5 to a third party on the tribe's or tribal organiza-
6 tion's behalf, under the agreement. The Secretary
7 has the right to recover tangible property (including
8 supplies), and equipment, less depreciation, and any
9 funds expended for operations and maintenance
10 under this section. The preceding sentence shall not
11 apply to any funds expended for the delivery of
12 health care services, or for personnel or staffing.

13 “(d) RECOVERY FOR NON-USE.—An Indian tribe or
14 tribal organization that has entered into a written agree-
15 ment with the Secretary under this section shall be enti-
16 tled to recover from the United States an amount that
17 is proportional to the value of such facility should at any
18 time within 10 years the Service ceases to use the facility
19 or otherwise breaches the agreement.

20 “(e) DEFINITION.—In this section, the terms ‘health
21 facility’ or ‘health facilities’ include staff quarters needed
22 to provide housing for the staff of the tribal health pro-
23 gram.

1 **“SEC. 313. LOCATION OF FACILITIES.**

2 “(a) PRIORITY.—The Bureau of Indian Affairs and
3 the Service shall, in all matters involving the reorganiza-
4 tion or development of Service facilities, or in the estab-
5 lishment of related employment projects to address unem-
6 ployment conditions in economically depressed areas, give
7 priority to locating such facilities and projects on Indian
8 lands if requested by the Indian owner and the Indian
9 tribe with jurisdiction over such lands or other lands
10 owned or leased by the Indian tribe or tribal organization
11 so long as priority is given to Indian land owned by an
12 Indian tribe or tribes.

13 “(b) DEFINITION.—In this section, the term ‘Indian
14 lands’ means—

15 “(1) all lands within the exterior boundaries of
16 any Indian reservation;

17 “(2) any lands title to which is held in trust by
18 the United States for the benefit of any Indian tribe
19 or individual Indian, or held by any Indian tribe or
20 individual Indian subject to restriction by the United
21 States against alienation and over which an Indian
22 tribe exercises governmental power; and

23 “(3) all lands in Alaska owned by any Alaska
24 Native village, or any village or regional corporation
25 under the Alaska Native Claims Settlement Act, or
26 any land allotted to any Alaska Native.

1 **“SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH**
2 **CARE FACILITIES.**

3 “(a) REPORT.—The Secretary shall submit to the
4 President, for inclusion in the report required to be trans-
5 mitted to Congress under section 801, a report that identi-
6 fies the backlog of maintenance and repair work required
7 at both Service and tribal facilities, including new facilities
8 expected to be in operation in the fiscal year after the year
9 for which the report is being prepared. The report shall
10 identify the need for renovation and expansion of existing
11 facilities to support the growth of health care programs.

12 “(b) MAINTENANCE OF NEWLY CONSTRUCTED
13 SPACE.—

14 “(1) IN GENERAL.—The Secretary may expend
15 maintenance and improvement funds to support the
16 maintenance of newly constructed space only if such
17 space falls within the approved supportable space al-
18 location for the Indian tribe or tribal organization.

19 “(2) DEFINITION.—For purposes of paragraph
20 (1), the term ‘supportable space allocation’ shall be
21 defined through the negotiated rulemaking process
22 provided for under section 802.

23 “(c) CONSTRUCTION OF REPLACEMENT FACILI-
24 TIES.—

25 “(1) IN GENERAL.—In addition to using main-
26 tenance and improvement funds for the maintenance

1 of facilities under subsection (b)(1), an Indian tribe
 2 or tribal organization may use such funds for the
 3 construction of a replacement facility if the costs of
 4 the renovation of such facility would exceed a maxi-
 5 mum renovation cost threshold.

6 “(2) DEFINITION.—For purposes of paragraph
 7 (1), the term ‘maximum renovation cost threshold’
 8 shall be defined through the negotiated rulemaking
 9 process provided for under section 802.

10 **“SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED**
 11 **QUARTERS.**

12 “(a) ESTABLISHMENT OF RENTAL RATES.—

13 “(1) IN GENERAL.—Notwithstanding any other
 14 provision of law, an Indian tribe or tribal organiza-
 15 tion which operates a hospital or other health facility
 16 and the federally-owned quarters associated there-
 17 with, pursuant to a funding agreement under the In-
 18 dian Self-Determination and Education Assistance
 19 Act, may establish the rental rates charged to the
 20 occupants of such quarters by providing notice to
 21 the Secretary of its election to exercise such author-
 22 ity.

23 “(2) OBJECTIVES.—In establishing rental rates
 24 under paragraph (1), an Indian tribe or tribal orga-

1 nization shall attempt to achieve the following objec-
2 tives:

3 “(A) The rental rates should be based on
4 the reasonable value of the quarters to the oc-
5 cupants thereof.

6 “(B) The rental rates should generate suf-
7 ficient funds to prudently provide for the oper-
8 ation and maintenance of the quarters, and,
9 subject to the discretion of the Indian tribe or
10 tribal organization, to supply reserve funds for
11 capital repairs and replacement of the quarters.

12 “(3) ELIGIBILITY FOR QUARTERS IMPROVE-
13 MENT AND REPAIR.—Any quarters whose rental
14 rates are established by an Indian tribe or tribal or-
15 ganization under this subsection shall continue to be
16 eligible for quarters improvement and repair funds
17 to the same extent as other federally-owned quarters
18 that are used to house personnel in Service-sup-
19 ported programs.

20 “(4) NOTICE OF CHANGE IN RATES.—An In-
21 dian tribe or tribal organization that exercises the
22 authority provided under this subsection shall pro-
23 vide occupants with not less than 60 days notice of
24 any change in rental rates.

25 “(b) COLLECTION OF RENTS.—

1 “(1) IN GENERAL.—Notwithstanding any other
2 provision of law, and subject to paragraph (2), an
3 Indian tribe or a tribal organization that operates
4 federally-owned quarters pursuant to a funding
5 agreement under the Indian Self-Determination and
6 Education Assistance Act shall have the authority to
7 collect rents directly from Federal employees who oc-
8 cupy such quarters in accordance with the following:

9 “(A) The Indian tribe or tribal organiza-
10 tion shall notify the Secretary and the Federal
11 employees involved of its election to exercise its
12 authority to collect rents directly from such
13 Federal employees.

14 “(B) Upon the receipt of a notice described
15 in subparagraph (A), the Federal employees in-
16 volved shall pay rents for the occupancy of such
17 quarters directly to the Indian tribe or tribal
18 organization and the Secretary shall have no
19 further authority to collect rents from such em-
20 ployees through payroll deduction or otherwise.

21 “(C) Such rent payments shall be retained
22 by the Indian tribe or tribal organization and
23 shall not be made payable to or otherwise be
24 deposited with the United States.

1 “(D) Such rent payments shall be depos-
2 ited into a separate account which shall be used
3 by the Indian tribe or tribal organization for
4 the maintenance (including capital repairs and
5 replacement expenses) and operation of the
6 quarters and facilities as the Indian tribe or
7 tribal organization shall determine appropriate.

8 “(2) RETROCESSION.—If an Indian tribe or
9 tribal organization which has made an election under
10 paragraph (1) requests retrocession of its authority
11 to directly collect rents from Federal employees oc-
12 cupying federally-owned quarters, such retrocession
13 shall become effective on the earlier of—

14 “(A) the first day of the month that begins
15 not less than 180 days after the Indian tribe or
16 tribal organization notifies the Secretary of its
17 desire to retrocede; or

18 “(B) such other date as may be mutually
19 agreed upon by the Secretary and the Indian
20 tribe or tribal organization.

21 “(c) RATES.—To the extent that an Indian tribe or
22 tribal organization, pursuant to authority granted in sub-
23 section (a), establishes rental rates for federally-owned
24 quarters provided to a Federal employee in Alaska, such
25 rents may be based on the cost of comparable private rent-

1 al housing in the nearest established community with a
2 year-round population of 1,500 or more individuals.

3 **“SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIRE-**
4 **MENT.**

5 “(a) IN GENERAL.—The Secretary shall ensure that
6 the requirements of the Buy American Act apply to all
7 procurements made with funds provided pursuant to the
8 authorization contained in section 318, except that Indian
9 tribes and tribal organizations shall be exempt from such
10 requirements.

11 “(b) FALSE OR MISLEADING LABELING.—If it has
12 been finally determined by a court or Federal agency that
13 any person intentionally affixed a label bearing a ‘Made
14 in America’ inscription, or any inscription with the same
15 meaning, to any product sold in or shipped to the United
16 States that is not made in the United States, such person
17 shall be ineligible to receive any contract or subcontract
18 made with funds provided pursuant to the authorization
19 contained in section 318, pursuant to the debarment, sus-
20 pension, and ineligibility procedures described in sections
21 9.400 through 9.409 of title 48, Code of Federal Regula-
22 tions.

23 “(c) DEFINITION.—In this section, the term ‘Buy
24 American Act’ means title III of the Act entitled ‘An Act
25 making appropriations for the Treasury and Post Office

1 Departments for the fiscal year ending June 30, 1934,
2 and for other purposes', approved March 3, 1933 (41
3 U.S.C. 10a et seq.).

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

5 "Notwithstanding any other provision of law—

6 "(1) the Secretary may accept from any source,
7 including Federal and State agencies, funds that are
8 available for the construction of health care facilities
9 and use such funds to plan, design and construct
10 health care facilities for Indians and to place such
11 funds into funding agreements authorized under the
12 Indian Self-Determination and Education Assistance
13 Act (25 U.S.C. 450f et seq.) between the Secretary
14 and an Indian tribe or tribal organization, except
15 that the receipt of such funds shall not have an ef-
16 fect on the priorities established pursuant to section
17 301;

18 "(2) the Secretary may enter into interagency
19 agreements with other Federal or State agencies and
20 other entities and to accept funds from such Federal
21 or State agencies or other entities to provide for the
22 planning, design and construction of health care fa-
23 cilities to be administered by the Service or by In-
24 dian tribes or tribal organizations under the Indian
25 Self-Determination and Education Assistance Act in

1 order to carry out the purposes of this Act, together
2 with the purposes for which such funds are appro-
3 priated to such other Federal or State agency or for
4 which the funds were otherwise provided;

5 “(3) any Federal agency to which funds for the
6 construction of health care facilities are appropriated
7 is authorized to transfer such funds to the Secretary
8 for the construction of health care facilities to carry
9 out the purposes of this Act as well as the purposes
10 for which such funds are appropriated to such other
11 Federal agency; and

12 “(4) the Secretary, acting through the Service,
13 shall establish standards under regulations developed
14 through rulemaking under section 802, for the plan-
15 ning, design and construction of health care facilities
16 serving Indians under this Act.

17 **“SEC. 318. AUTHORIZATION OF APPROPRIATIONS.**

18 “There is authorized to be appropriated such sums
19 as may be necessary for each fiscal year through fiscal
20 year 2015 to carry out this title.

1 **“TITLE IV—ACCESS TO HEALTH**
2 **SERVICES**

3 **“SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE**
4 **PROGRAM.**

5 “(a) IN GENERAL.—Any payments received by the
6 Service, by an Indian tribe or tribal organization pursuant
7 to a funding agreement under the Indian Self-Determina-
8 tion and Education Assistance Act, or by an urban Indian
9 organization pursuant to title V of this Act for services
10 provided to Indians eligible for benefits under title XVIII
11 of the Social Security Act shall not be considered in deter-
12 mining appropriations for health care and services to Indi-
13 ans.

14 “(b) EQUAL TREATMENT.—Nothing in this Act au-
15 thorizes the Secretary to provide services to an Indian ben-
16 eficiary with coverage under title XVIII of the Social Secu-
17 rity Act in preference to an Indian beneficiary without
18 such coverage.

19 “(c) SPECIAL FUND.—

20 “(1) USE OF FUNDS.—Notwithstanding any
21 other provision of this title or of title XVIII of the
22 Social Security Act, payments to which any facility
23 of the Service is entitled by reason of this section
24 shall be placed in a special fund to be held by the
25 Secretary and first used (to such extent or in such

1 amounts as are provided in appropriation Acts) for
 2 the purpose of making any improvements in the pro-
 3 grams of the Service which may be necessary to
 4 achieve or maintain compliance with the applicable
 5 conditions and requirements of this title and of title
 6 XVIII of the Social Security Act. Any funds to be
 7 reimbursed which are in excess of the amount nec-
 8 essary to achieve or maintain such conditions and
 9 requirements shall, subject to the consultation with
 10 tribes being served by the service unit, be used for
 11 reducing the health resource deficiencies of the In-
 12 dian tribes.

13 “(2) NONAPPLICATION IN CASE OF ELECTION
 14 FOR DIRECT BILLING.—Paragraph (1) shall not
 15 apply upon the election of an Indian tribe or tribal
 16 organization under section 405 to receive direct pay-
 17 ments for services provided to Indians eligible for
 18 benefits under title XVIII of the Social Security Act.

19 **“SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID**
 20 **PROGRAM.**

21 “(a) SPECIAL FUND.—

22 “(1) USE OF FUNDS.—Notwithstanding any
 23 other provision of law, payments to which any facil-
 24 ity of the Service (including a hospital, nursing facil-
 25 ity, intermediate care facility for the mentally re-

1 tarded, or any other type of facility which provides
2 services for which payment is available under title
3 XIX of the Social Security Act) is entitled under a
4 State plan by reason of section 1911 of such Act
5 shall be placed in a special fund to be held by the
6 Secretary and first used (to such extent or in such
7 amounts as are provided in appropriation Acts) for
8 the purpose of making any improvements in the fa-
9 cilities of such Service which may be necessary to
10 achieve or maintain compliance with the applicable
11 conditions and requirements of such title. Any pay-
12 ments which are in excess of the amount necessary
13 to achieve or maintain such conditions and require-
14 ments shall, subject to the consultation with tribes
15 being served by the service unit, be used for reduc-
16 ing the health resource deficiencies of the Indian
17 tribes. In making payments from such fund, the Sec-
18 retary shall ensure that each service unit of the
19 Service receives 100 percent of the amounts to which
20 the facilities of the Service, for which such service
21 unit makes collections, are entitled by reason of sec-
22 tion 1911 of the Social Security Act.

23 “(2) NONAPPLICATION IN CASE OF ELECTION
24 FOR DIRECT BILLING.—Paragraph (1) shall not
25 apply upon the election of an Indian tribe or tribal

1 organization under section 405 to receive direct pay-
 2 ments for services provided to Indians eligible for
 3 medical assistance under title XIX of the Social Se-
 4 curity Act.

5 “(b) PAYMENTS DISREGARDED FOR APPROPRIA-
 6 TIONS.—Any payments received under section 1911 of the
 7 Social Security Act for services provided to Indians eligible
 8 for benefits under title XIX of the Social Security Act
 9 shall not be considered in determining appropriations for
 10 the provision of health care and services to Indians.

11 “(c) DIRECT BILLING.—For provisions relating to
 12 the authority of certain Indian tribes and tribal organiza-
 13 tions to elect to directly bill for, and receive payment for,
 14 health care services provided by a hospital or clinic of such
 15 tribes or tribal organizations and for which payment may
 16 be made under this title, see section 405.

17 **“SEC. 403. REPORT.**

18 “(a) INCLUSION IN ANNUAL REPORT.—The Sec-
 19 retary shall submit to the President, for inclusion in the
 20 report required to be transmitted to the Congress under
 21 section 801, an accounting on the amount and use of
 22 funds made available to the Service pursuant to this title
 23 as a result of reimbursements under titles XVIII and XIX
 24 of the Social Security Act.

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

12 **“SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH**
 13 **THE SERVICE, INDIAN TRIBES OR TRIBAL OR-**
 14 **GANIZATIONS, AND URBAN INDIAN ORGANI-**
 15 **ZATIONS.**

16 “(a) IN GENERAL.—The Secretary shall make grants
 17 to or enter into funding agreements with Indian tribes and
 18 tribal organizations to assist such organizations in estab-
 19 lishing and administering programs on or near Federal In-
 20 dian reservations and trust areas and in or near Alaska
 21 Native villages to assist individual Indians to—

22 “(1) enroll under sections 1818, 1836, and
 23 1837 of the Social Security Act;

24 “(2) pay premiums for health insurance cov-
 25 erage; and

1 “(3) apply for medical assistance provided pur-
2 suant to titles XIX and XXI of the Social Security
3 Act.

4 “(b) CONDITIONS.—The Secretary shall place condi-
5 tions as deemed necessary to effect the purpose of this
6 section in any funding agreement or grant which the Sec-
7 retary makes with any Indian tribe or tribal organization
8 pursuant to this section. Such conditions shall include, but
9 are not limited to, requirements that the organization suc-
10 cessfully undertake to—

11 “(1) determine the population of Indians to be
12 served that are or could be recipients of benefits or
13 assistance under titles XVIII, XIX, and XXI of the
14 Social Security Act;

15 “(2) assist individual Indians in becoming fa-
16 miliar with and utilizing such benefits and assist-
17 ance;

18 “(3) provide transportation to such individual
19 Indians to the appropriate offices for enrollment or
20 applications for such benefits and assistance;

21 “(4) develop and implement—

22 “(A) a schedule of income levels to deter-
23 mine the extent of payments of premiums by
24 such organizations for health insurance cov-
25 erage of needy individuals; and

1 “(B) methods of improving the participa-
2 tion of Indians in receiving the benefits and as-
3 sistance provided under titles XVIII, XIX, and
4 XXI of the Social Security Act.

5 “(c) AGREEMENTS FOR RECEIPT AND PROCESSING
6 OF APPLICATIONS.—The Secretary may enter into an
7 agreement with an Indian tribe or tribal organization, or
8 an urban Indian organization, which provides for the re-
9 ceipt and processing of applications for medical assistance
10 under title XIX of the Social Security Act, child health
11 assistance under title XXI of such Act and benefits under
12 title XVIII of such Act by a Service facility or a health
13 care program administered by such Indian tribe or tribal
14 organization, or urban Indian organization, pursuant to
15 a funding agreement under the Indian Self-Determination
16 and Education Assistance Act or a grant or contract en-
17 tered into with an urban Indian organization under title
18 V of this Act. Notwithstanding any other provision of law,
19 such agreements shall provide for reimbursement of the
20 cost of outreach, education regarding eligibility and bene-
21 fits, and translation when such services are provided. The
22 reimbursement may be included in an encounter rate or
23 be made on a fee-for-service basis as appropriate for the
24 provider. When necessary to carry out the terms of this
25 section, the Secretary, acting through the Health Care Fi-

1 nancing Administration or the Service, may enter into
 2 agreements with a State (or political subdivision thereof)
 3 to facilitate cooperation between the State and the Service,
 4 an Indian tribe or tribal organization, and an urban In-
 5 dian organization.

6 “(d) GRANTS.—

7 “(1) IN GENERAL.—The Secretary shall make
 8 grants or enter into contracts with urban Indian or-
 9 ganizations to assist such organizations in establish-
 10 ing and administering programs to assist individual
 11 urban Indians to—

12 “(A) enroll under sections 1818, 1836, and
 13 1837 of the Social Security Act;

14 “(B) pay premiums on behalf of such indi-
 15 viduals for coverage under title XVIII of such
 16 Act; and

17 “(C) apply for medical assistance provided
 18 under title XIX of such Act and for child health
 19 assistance under title XXI of such Act.

20 “(2) REQUIREMENTS.—The Secretary shall in-
 21 clude in the grants or contracts made or entered
 22 into under paragraph (1) requirements that are—

23 “(A) consistent with the conditions im-
 24 posed by the Secretary under subsection (b);

1 “(B) appropriate to urban Indian organi-
 2 zations and urban Indians; and

3 “(C) necessary to carry out the purposes of
 4 this section.

5 **“SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF**
 6 **MEDICARE, MEDICAID, AND OTHER THIRD**
 7 **PARTY PAYORS.**

8 “(a) ESTABLISHMENT OF DIRECT BILLING PRO-
 9 GRAM.—

10 “(1) IN GENERAL.—The Secretary shall estab-
 11 lish a program under which Indian tribes, tribal or-
 12 ganizations, and Alaska Native health organizations
 13 that contract or compact for the operation of a hos-
 14 pital or clinic of the Service under the Indian Self-
 15 Determination and Education Assistance Act may
 16 elect to directly bill for, and receive payment for,
 17 health care services provided by such hospital or
 18 clinic for which payment is made under the medicare
 19 program established under title XVIII of the Social
 20 Security Act (42 U.S.C. 1395 et seq.), under the
 21 medicaid program established under title XIX of the
 22 Social Security Act (42 U.S.C. 1396 et seq.), or
 23 from any other third party payor.

24 “(2) APPLICATION OF 100 PERCENT FMAP.—
 25 The third sentence of section 1905(b) of the Social

1 Security Act (42 U.S.C. 1396d(b)) shall apply for
2 purposes of reimbursement under title XIX of the
3 Social Security Act for health care services directly
4 billed under the program established under this sec-
5 tion.

6 “(b) DIRECT REIMBURSEMENT.—

7 “(1) USE OF FUNDS.—Each hospital or clinic
8 participating in the program described in subsection
9 (a) of this section shall be reimbursed directly under
10 titles XVIII and XIX of the Social Security Act for
11 services furnished, without regard to the provisions
12 of section 1880(c) of the Social Security Act (42
13 U.S.C. 1395qq(c)) and sections 402(a) and
14 807(b)(2)(A), but all funds so reimbursed shall first
15 be used by the hospital or clinic for the purpose of
16 making any improvements in the hospital or clinic
17 that may be necessary to achieve or maintain com-
18 pliance with the conditions and requirements appli-
19 cable generally to facilities of such type under title
20 XVIII or XIX of the Social Security Act. Any funds
21 so reimbursed which are in excess of the amount
22 necessary to achieve or maintain such conditions
23 shall be used—

24 “(A) solely for improving the health re-
25 sources deficiency level of the Indian tribe; and

1 “(B) in accordance with the regulations of
2 the Service applicable to funds provided by the
3 Service under any contract entered into under
4 the Indian Self-Determination Act (25 U.S.C.
5 450f et seq.).

6 “(2) AUDITS.—The amounts paid to the hos-
7 pitals and clinics participating in the program estab-
8 lished under this section shall be subject to all audit-
9 ing requirements applicable to programs adminis-
10 tered directly by the Service and to facilities partici-
11 pating in the medicare and medicaid programs
12 under titles XVIII and XIX of the Social Security
13 Act.

14 “(3) SECRETARIAL OVERSIGHT.—The Secretary
15 shall monitor the performance of hospitals and clin-
16 ics participating in the program established under
17 this section, and shall require such hospitals and
18 clinics to submit reports on the program to the Sec-
19 retary on an annual basis.

20 “(4) NO PAYMENTS FROM SPECIAL FUNDS.—
21 Notwithstanding section 1880(c) of the Social Secu-
22 rity Act (42 U.S.C. 1395qq(e)) or section 402(a), no
23 payment may be made out of the special funds de-
24 scribed in such sections for the benefit of any hos-
25 pital or clinic during the period that the hospital or

1 clinic participates in the program established under
2 this section.

3 “(c) REQUIREMENTS FOR PARTICIPATION.—

4 “(1) APPLICATION.—Except as provided in
5 paragraph (2)(B), in order to be eligible for partici-
6 pation in the program established under this section,
7 an Indian tribe, tribal organization, or Alaska Na-
8 tive health organization shall submit an application
9 to the Secretary that establishes to the satisfaction
10 of the Secretary that—

11 “(A) the Indian tribe, tribal organization,
12 or Alaska Native health organization contracts
13 or compacts for the operation of a facility of the
14 Service;

15 “(B) the facility is eligible to participate in
16 the medicare or medicaid programs under sec-
17 tion 1880 or 1911 of the Social Security Act
18 (42 U.S.C. 1395qq; 1396j);

19 “(C) the facility meets the requirements
20 that apply to programs operated directly by the
21 Service; and

22 “(D) the facility—

23 “(i) is accredited by an accrediting
24 body as eligible for reimbursement under
25 the medicare or medicaid programs; or

1 “(ii) has submitted a plan, which has
2 been approved by the Secretary, for achiev-
3 ing such accreditation.

4 “(2) APPROVAL.—

5 “(A) IN GENERAL.—The Secretary shall
6 review and approve a qualified application not
7 later than 90 days after the date the applica-
8 tion is submitted to the Secretary unless the
9 Secretary determines that any of the criteria set
10 forth in paragraph (1) are not met.

11 “(B) GRANDFATHER OF DEMONSTRATION
12 PROGRAM PARTICIPANTS.—Any participant in
13 the demonstration program authorized under
14 this section as in effect on the day before the
15 date of enactment of the Alaska Native and
16 American Indian Direct Reimbursement Act of
17 2000 shall be deemed approved for participa-
18 tion in the program established under this sec-
19 tion and shall not be required to submit an ap-
20 plication in order to participate in the program.

21 “(C) DURATION.—An approval by the Sec-
22 retary of a qualified application under subpara-
23 graph (A), or a deemed approval of a dem-
24 onstration program under subparagraph (B),
25 shall continue in effect as long as the approved

1 applicant or the deemed approved demonstra-
 2 tion program meets the requirements of this
 3 section.

4 “(d) EXAMINATION AND IMPLEMENTATION OF
 5 CHANGES.—

6 “(1) IN GENERAL.—The Secretary, acting
 7 through the Service, and with the assistance of the
 8 Administrator of the Health Care Financing Admin-
 9 istration, shall examine on an ongoing basis and
 10 implement—

11 “(A) any administrative changes that may
 12 be necessary to facilitate direct billing and re-
 13 imbursement under the program established
 14 under this section, including any agreements
 15 with States that may be necessary to provide
 16 for direct billing under title XIX of the Social
 17 Security Act; and

18 “(B) any changes that may be necessary to
 19 enable participants in the program established
 20 under this section to provide to the Service
 21 medical records information on patients served
 22 under the program that is consistent with the
 23 medical records information system of the Serv-
 24 ice.

1 “(2) ACCOUNTING INFORMATION.—The ac-
2 counting information that a participant in the pro-
3 gram established under this section shall be required
4 to report shall be the same as the information re-
5 quired to be reported by participants in the dem-
6 onstration program authorized under this section as
7 in effect on the day before the date of enactment of
8 the Alaska Native and American Indian Direct Re-
9 imbursement Act of 2000. The Secretary may from
10 time to time, after consultation with the program
11 participants, change the accounting information sub-
12 mission requirements.

13 “(e) WITHDRAWAL FROM PROGRAM.—A participant
14 in the program established under this section may with-
15 draw from participation in the same manner and under
16 the same conditions that a tribe or tribal organization may
17 retrocede a contracted program to the Secretary under au-
18 thority of the Indian Self-Determination Act (25 U.S.C.
19 450 et seq.). All cost accounting and billing authority
20 under the program established under this section shall be
21 returned to the Secretary upon the Secretary’s acceptance
22 of the withdrawal of participation in this program.

1 **“SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PAR-**
2 **TIES OF COSTS OF HEALTH SERVICES.**

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

13 “(1) such services had been provided by a non-
14 governmental provider; and

15 “(2) such individual had been required to pay
16 such charges or expenses and did pay such expenses.

17 “(b) URBAN INDIAN ORGANIZATIONS.—Except as
18 provided in subsection (g), an urban Indian organization
19 shall have the right to recover the reasonable charges
20 billed or expenses incurred by the organization in provid-
21 ing health services to any individual to the same extent
22 that such individual, or any other nongovernmental pro-
23 vider of such services, would be eligible to receive reim-
24 bursement or indemnification for such charges or expenses
25 if such individual had been required to pay such charges
26 or expenses and did pay such charges or expenses.

1 “(c) LIMITATIONS ON RECOVERIES FROM STATES.—

2 Subsections (a) and (b) shall provide a right of recovery
3 against any State, only if the injury, illness, or disability
4 for which health services were provided is covered under—

5 “(1) workers’ compensation laws; or

6 “(2) a no-fault automobile accident insurance
7 plan or program.

8 “(d) NONAPPLICATION OF OTHER LAWS.—No law of

9 any State, or of any political subdivision of a State and
10 no provision of any contract entered into or renewed after
11 the date of enactment of the Indian Health Care Amend-
12 ments of 1988, shall prevent or hinder the right of recov-
13 ery of the United States or an Indian tribe or tribal orga-
14 nization under subsection (a), or an urban Indian organi-
15 zation under subsection (b).

16 “(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—

17 No action taken by the United States or an Indian tribe
18 or tribal organization to enforce the right of recovery pro-
19 vided under subsection (a), or by an urban Indian organi-
20 zation to enforce the right of recovery provided under sub-
21 section (b), shall affect the right of any person to any
22 damages (other than damages for the cost of health serv-
23 ices provided by the Secretary through the Service).

24 “(f) METHODS OF ENFORCEMENT.—

1 “(1) IN GENERAL.—The United States or an
2 Indian tribe or tribal organization may enforce the
3 right of recovery provided under subsection (a), and
4 an urban Indian organization may enforce the right
5 of recovery provided under subsection (b), by—

6 “(A) intervening or joining in any civil ac-
7 tion or proceeding brought—

8 “(i) by the individual for whom health
9 services were provided by the Secretary, an
10 Indian tribe or tribal organization, or
11 urban Indian organization; or

12 “(ii) by any representative or heirs of
13 such individual; or

14 “(B) instituting a civil action.

15 “(2) NOTICE.—All reasonable efforts shall be
16 made to provide notice of an action instituted in ac-
17 cordance with paragraph (1)(B) to the individual to
18 whom health services were provided, either before or
19 during the pendency of such action.

20 “(g) LIMITATION.—Notwithstanding this section, ab-
21 sent specific written authorization by the governing body
22 of an Indian tribe for the period of such authorization
23 (which may not be for a period of more than 1 year and
24 which may be revoked at any time upon written notice by
25 the governing body to the Service), neither the United

1 States through the Service, nor an Indian tribe or tribal
2 organization under a funding agreement pursuant to the
3 Indian Self-Determination and Education Assistance Act,
4 nor an urban Indian organization funded under title V,
5 shall have a right of recovery under this section if the in-
6 jury, illness, or disability for which health services were
7 provided is covered under a self-insurance plan funded by
8 an Indian tribe or tribal organization, or urban Indian or-
9 ganization. Where such tribal authorization is provided,
10 the Service may receive and expend such funds for the
11 provision of additional health services.

12 “(h) COSTS AND ATTORNEYS’ FEES.—In any action
13 brought to enforce the provisions of this section, a prevail-
14 ing plaintiff shall be awarded reasonable attorneys’ fees
15 and costs of litigation.

16 “(i) RIGHT OF ACTION AGAINST INSURERS AND EM-
17 PLOYEE BENEFIT PLANS.—

18 “(1) IN GENERAL.—Where an insurance com-
19 pany or employee benefit plan fails or refuses to pay
20 the amount due under subsection (a) for services
21 provided to an individual who is a beneficiary, par-
22 ticipant, or insured of such company or plan, the
23 United States or an Indian tribe or tribal organiza-
24 tion shall have a right to assert and pursue all the
25 claims and remedies against such company or plan,

1 and against the fiduciaries of such company or plan,
2 that the individual could assert or pursue under ap-
3 plicable Federal, State or tribal law.

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

15 “(j) NONAPPLICATION OF CLAIMS FILING REQUIRE-
16 MENTS.—Notwithstanding any other provision in law, the
17 Service, an Indian tribe or tribal organization, or an urban
18 Indian organization shall have a right of recovery for any
19 otherwise reimbursable claim filed on a current HCFA-
20 1500 or UB-92 form, or the current NSF electronic for-
21 mat, or their successors. No health plan shall deny pay-
22 ment because a claim has not been submitted in a unique
23 format that differs from such forms.

1 **“SEC. 407. CREDITING OF REIMBURSEMENTS.**

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

15 “(b) NO OFFSET OF FUNDS.—The Service may not
16 offset or limit the amount of funds obligated to any service
17 unit or entity receiving funding from the Service because
18 of the receipt of reimbursements under subsection (a).

19 **“SEC. 408. PURCHASING HEALTH CARE COVERAGE.**

20 “An Indian tribe or tribal organization, and an urban
21 Indian organization may utilize funding from the Sec-
22 retary under this Act to purchase managed care coverage
23 for Service beneficiaries (including insurance to limit the
24 financial risks of managed care entities) from—

25 “(1) a tribally owned and operated managed
26 care plan;

1 “(2) a State or locally-authorized or licensed
2 managed care plan; or

3 “(3) a health insurance provider.

4 **“SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VET-**
5 **ERAN’S AFFAIRS, AND OTHER FEDERAL**
6 **AGENCY HEALTH FACILITIES AND SERVICES**
7 **SHARING.**

8 “(a) EXAMINATION OF FEASIBILITY OF ARRANGE-
9 MENTS.—

10 “(1) IN GENERAL.—The Secretary shall exam-
11 ine the feasibility of entering into arrangements or
12 expanding existing arrangements for the sharing of
13 medical facilities and services between the Service
14 and the Veterans’ Administration, and other appro-
15 priate Federal agencies, including those within the
16 Department, and shall, in accordance with sub-
17 section (b), prepare a report on the feasibility of
18 such arrangements.

19 “(2) SUBMISSION OF REPORT.—Not later than
20 September 30, 2003, the Secretary shall submit the
21 report required under paragraph (1) to Congress.

22 “(3) CONSULTATION REQUIRED.—The Sec-
23 retary may not finalize any arrangement described
24 in paragraph (1) without first consulting with the
25 affected Indian tribes.

1 “(b) LIMITATIONS.—The Secretary shall not take
2 any action under this section or under subchapter IV of
3 chapter 81 of title 38, United States Code, which would
4 impair—

5 “(1) the priority access of any Indian to health
6 care services provided through the Service;

7 “(2) the quality of health care services provided
8 to any Indian through the Service;

9 “(3) the priority access of any veteran to health
10 care services provided by the Veterans’ Administra-
11 tion;

12 “(4) the quality of health care services provided
13 to any veteran by the Veteran’s Administration;

14 “(5) the eligibility of any Indian to receive
15 health services through the Service; or

16 “(6) the eligibility of any Indian who is a vet-
17 eran to receive health services through the Veterans’
18 Administration provided, however, the Service or the
19 Indian tribe or tribal organization shall be reim-
20 bursed by the Veterans’ Administration where serv-
21 ices are provided through the Service or Indian
22 tribes or tribal organizations to beneficiaries eligible
23 for services from the Veterans’ Administration, not-
24 withstanding any other provision of law.

1 “(c) AGREEMENTS FOR PARITY IN SERVICES.—The
2 Service may enter into agreements with other Federal
3 agencies to assist in achieving parity in services for Indi-
4 ans. Nothing in this section may be construed as creating
5 any right of a veteran to obtain health services from the
6 Service.

7 **“SEC. 410. PAYOR OF LAST RESORT.**

8 “The Service, and programs operated by Indian
9 tribes or tribal organizations, or urban Indian organiza-
10 tions shall be the payor of last resort for services provided
11 to individuals eligible for services from the Service and
12 such programs, notwithstanding any Federal, State or
13 local law to the contrary, unless such law explicitly pro-
14 vides otherwise.

15 **“SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH**
16 **CARE PROGRAMS.**

17 “Notwithstanding any other provision of law, the
18 Service, Indian tribes or tribal organizations, and urban
19 Indian organizations (notwithstanding limitations on who
20 is eligible to receive services from such entities) shall be
21 entitled to receive payment or reimbursement for services
22 provided by such entities from any federally funded health
23 care program, unless there is an explicit prohibition on
24 such payments in the applicable authorizing statute.

1 **“SEC. 412. TUBA CITY DEMONSTRATION PROJECT.**

2 “(a) IN GENERAL.—Notwithstanding any other pro-
3 vision of law, including the Anti-Deficiency Act, provided
4 the Indian tribes to be served approve, the Service in the
5 Tuba City Service Unit may—

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

13 “(2) purchase insurance to limit the financial
14 risks under the project.

15 “(b) EXTENSION OF PROJECT.—The demonstration
16 project authorized under subsection (a) may be extended
17 to other service units in Arizona, subject to the approval
18 of the Indian tribes to be served in such service units, the
19 Service, and the State of Arizona.

20 **“SEC. 413. ACCESS TO FEDERAL INSURANCE.**

21 “Notwithstanding the provisions of title 5, United
22 States Code, Executive Order, or administrative regula-
23 tion, an Indian tribe or tribal organization carrying out
24 programs under the Indian Self-Determination and Edu-
25 cation Assistance Act or an urban Indian organization car-
26 rying out programs under title V of this Act shall be enti-

1 tled to purchase coverage, rights and benefits for the em-
 2 ployees of such Indian tribe or tribal organization, or
 3 urban Indian organization, under chapter 89 of title 5,
 4 United States Code, and chapter 87 of such title if nec-
 5 essary employee deductions and agency contributions in
 6 payment for the coverage, rights, and benefits for the pe-
 7 riod of employment with such Indian tribe or tribal organi-
 8 zation, or urban Indian organization, are currently depos-
 9 ited in the applicable Employee's Fund under such title.

10 **“SEC. 414. CONSULTATION AND RULEMAKING.**

11 “(a) CONSULTATION.—Prior to the adoption of any
 12 policy or regulation by the Health Care Financing Admin-
 13 istration, the Secretary shall require the Administrator of
 14 that Administration to—

15 “(1) identify the impact such policy or regula-
 16 tion may have on the Service, Indian tribes or tribal
 17 organizations, and urban Indian organizations;

18 “(2) provide to the Service, Indian tribes or
 19 tribal organizations, and urban Indian organizations
 20 the information described in paragraph (1);

21 “(3) engage in consultation, consistent with the
 22 requirements of Executive Order 13084 of May 14,
 23 1998, with the Service, Indian tribes or tribal orga-
 24 nizations, and urban Indian organizations prior to
 25 enacting any such policy or regulation.

1 “(b) RULEMAKING.—The Administrator of the
2 Health Care Financing Administration shall participate in
3 the negotiated rulemaking provided for under title VIII
4 with regard to any regulations necessary to implement the
5 provisions of this title that relate to the Social Security
6 Act.

7 **“SEC. 415. LIMITATIONS ON CHARGES.**

8 “No provider of health services that is eligible to re-
9 ceive payments or reimbursements under titles XVIII,
10 XIX, or XXI of the Social Security Act or from any feder-
11 ally funded (whether in whole or part) health care pro-
12 gram may seek to recover payment for services—

13 “(1) that are covered under and furnished to an
14 individual eligible for the contract health services
15 program operated by the Service, by an Indian tribe
16 or tribal organization, or furnished to an urban In-
17 dian eligible for health services purchased by an
18 urban Indian organization, in an amount in excess
19 of the lowest amount paid by any other payor for
20 comparable services; or

21 “(2) for examinations or other diagnostic proce-
22 dures that are not medically necessary if such proce-
23 dures have already been performed by the referring
24 Indian health program and reported to the provider.

1 **“SEC. 416. LIMITATION ON SECRETARY’S WAIVER AUTHOR-**
 2 **ITY.**

3 “Notwithstanding any other provision of law, the Sec-
 4 retary may not waive the application of section
 5 1902(a)(13)(D) of the Social Security Act to any State
 6 plan under title XIX of the Social Security Act.

7 **“SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANC-**
 8 **TIONS.**

9 “Notwithstanding any other provision of law, the
 10 Service or an Indian tribe or tribal organization or an
 11 urban Indian organization operating a health program
 12 under the Indian Self-Determination and Education As-
 13 sistance Act shall be entitled to seek a waiver of sanctions
 14 imposed under title XVIII, XIX, or XXI of the Social Se-
 15 curity Act as if such entity were directly responsible for
 16 administering the State health care program.

17 **“SEC. 418. MEANING OF ‘REMUNERATION’ FOR PURPOSES**
 18 **OF SAFE HARBOR PROVISIONS; ANTITRUST**
 19 **IMMUNITY.**

20 “(a) MEANING OF REMUNERATION.—Notwithstand-
 21 ing any other provision of law, the term ‘remuneration’
 22 as used in sections 1128A and 1128B of the Social Secu-
 23 rity Act shall not include any exchange of anything of
 24 value between or among—

25 “(1) any Indian tribe or tribal organization or
 26 an urban Indian organization that administers

1 health programs under the authority of the Indian
2 Self-Determination and Education Assistance Act;

3 “(2) any such Indian tribe or tribal organiza-
4 tion or urban Indian organization and the Service;

5 “(3) any such Indian tribe or tribal organiza-
6 tion or urban Indian organization and any patient
7 served or eligible for service under such programs,
8 including patients served or eligible for service pur-
9 suant to section 813 of this Act (as in effect on the
10 day before the date of enactment of the Indian
11 Health Care Improvement Act Reauthorization of
12 2003); or

13 “(4) any such Indian tribe or tribal organiza-
14 tion or urban Indian organization and any third
15 party required by contract, section 206 or 207 of
16 this Act (as so in effect), or other applicable law, to
17 pay or reimburse the reasonable health care costs in-
18 curred by the United States or any such Indian tribe
19 or tribal organization or urban Indian organization;
20 provided the exchange arises from or relates to such health
21 programs.

22 “(b) ANTITRUST IMMUNITY.—An Indian tribe or
23 tribal organization or an urban Indian organization that
24 administers health programs under the authority of the
25 Indian Self-Determination and Education Assistance Act

1 or title V shall be deemed to be an agency of the United
2 States and immune from liability under the Acts com-
3 monly known as the Sherman Act, the Clayton Act, the
4 Robinson-Patman Anti-Discrimination Act, the Federal
5 Trade Commission Act, and any other Federal, State, or
6 local antitrust laws, with regard to any transaction, agree-
7 ment, or conduct that relates to such programs.

8 **“SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES**
9 **AND PREMIUMS.**

10 “(a) EXEMPTION FROM COST-SHARING REQUIRE-
11 MENTS.—Notwithstanding any other provision of Federal
12 or State law, no Indian who is eligible for services under
13 title XVIII, XIX, or XXI of the Social Security Act, or
14 under any other Federally funded health care programs,
15 may be charged a deductible, co-payment, or co-insurance
16 for any service provided by or through the Service, an In-
17 dian tribe or tribal organization or urban Indian organiza-
18 tion, nor may the payment or reimbursement due to the
19 Service or an Indian tribe or tribal organization or urban
20 Indian organization be reduced by the amount of the de-
21 ductible, co-payment, or co-insurance that would be due
22 from the Indian but for the operation of this section. For
23 the purposes of this section, the term ‘through’ shall in-
24 clude services provided directly, by referral, or under con-
25 tracts or other arrangements between the Service, an In-

1 dian tribe or tribal organization or an urban Indian orga-
2 nization and another health provider.

3 “(b) EXEMPTION FROM PREMIUMS.—

4 “(1) MEDICAID AND STATE CHILDREN’S
5 HEALTH INSURANCE PROGRAM.—Notwithstanding
6 any other provision of Federal or State law, no In-
7 dian who is otherwise eligible for medical assistance
8 under title XIX of the Social Security Act or child
9 health assistance under title XXI of such Act may
10 be charged a premium as a condition of receiving
11 such assistance under title XIX or XXI of such Act.

12 “(2) MEDICARE ENROLLMENT PREMIUM PEN-
13 ALTIES.—Notwithstanding section 1839(b) of the
14 Social Security Act or any other provision of Federal
15 or State law, no Indian who is eligible for benefits
16 under part B of title XVIII of the Social Security
17 Act, but for the payment of premiums, shall be
18 charged a penalty for enrolling in such part at a
19 time later than the Indian might otherwise have
20 been first eligible to do so. The preceding sentence
21 applies whether an Indian pays for premiums under
22 such part directly or such premiums are paid by an-
23 other person or entity, including a State, the Serv-
24 ice, an Indian tribe or tribal organization, or an
25 urban Indian organization.

1 **“SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR**
2 **PURPOSES OF MEDICALLY NEEDY MEDICAID**
3 **ELIGIBILITY.**

4 “For the purpose of determining the eligibility under
5 section 1902(a)(10)(A)(ii)(IV) of the Social Security Act
6 of an Indian for medical assistance under a State plan
7 under title XIX of such Act, the cost of providing services
8 to an Indian in a health program of the Service, an Indian
9 tribe or tribal organization, or an urban Indian organiza-
10 tion shall be deemed to have been an expenditure for
11 health care by the Indian.

12 **“SEC. 421. ESTATE RECOVERY PROVISIONS.**

13 “Notwithstanding any other provision of Federal or
14 State law, the following property may not be included
15 when determining eligibility for services or implementing
16 estate recovery rights under title XVIII, XIX, or XXI of
17 the Social Security Act, or any other health care programs
18 funded in whole or part with Federal funds:

19 “(1) Income derived from rents, leases, or roy-
20 alties of property held in trust for individuals by the
21 Federal Government.

22 “(2) Income derived from rents, leases, roy-
23 ties, or natural resources (including timber and fish-
24 ing activities) resulting from the exercise of federally
25 protected rights, whether collected by an individual
26 or a tribal group and distributed to individuals.

1 “(3) Property, including interests in real prop-
 2 erty currently or formerly held in trust by the Fed-
 3 eral Government which is protected under applicable
 4 Federal, State or tribal law or custom from re-
 5 course, including public domain allotments.

6 “(4) Property that has unique religious or cul-
 7 tural significance or that supports subsistence or
 8 traditional life style according to applicable tribal
 9 law or custom.

10 **“SEC. 422. MEDICAL CHILD SUPPORT.**

11 “Notwithstanding any other provision of law, a par-
 12 ent shall not be responsible for reimbursing the Federal
 13 Government or a State for the cost of medical services pro-
 14 vided to a child by or through the Service, an Indian tribe
 15 or tribal organization or an urban Indian organization.
 16 For the purposes of this subsection, the term ‘through’
 17 includes services provided directly, by referral, or under
 18 contracts or other arrangements between the Service, an
 19 Indian tribe or tribal organization or an urban Indian or-
 20 ganization and another health provider.

21 **“SEC. 423. PROVISIONS RELATING TO MANAGED CARE.**

22 “(a) RECOVERY FROM MANAGED CARE PLANS.—
 23 Notwithstanding any other provision in law, the Service,
 24 an Indian tribe or tribal organization or an urban Indian
 25 organization shall have a right of recovery under section

1 408 from all private and public health plans or programs,
2 including the medicare, medicaid, and State children's
3 health insurance programs under titles XVIII, XIX, and
4 XXI of the Social Security Act, for the reasonable costs
5 of delivering health services to Indians entitled to receive
6 services from the Service, an Indian tribe or tribal organi-
7 zation or an urban Indian organization.

8 “(b) LIMITATION.—No provision of law or regulation,
9 or of any contract, may be relied upon or interpreted to
10 deny or reduce payments otherwise due under subsection
11 (a), except to the extent the Service, an Indian tribe or
12 tribal organization, or an urban Indian organization has
13 entered into an agreement with a managed care entity re-
14 garding services to be provided to Indians or rates to be
15 paid for such services, provided that such an agreement
16 may not be made a prerequisite for such payments to be
17 made.

18 “(c) PARITY.—Payments due under subsection (a)
19 from a managed care entity may not be paid at a rate
20 that is less than the rate paid to a ‘preferred provider’
21 by the entity or, in the event there is no such rate, the
22 usual and customary fee for equivalent services.

23 “(d) NO CLAIM REQUIREMENT.—A managed care
24 entity may not deny payment under subsection (a) because
25 an enrollee with the entity has not submitted a claim.

1 “(e) DIRECT BILLING.—Notwithstanding the preced-
2 ing subsections of this section, the Service, an Indian tribe
3 or tribal organization, or an urban Indian organization
4 that provides a health service to an Indian entitled to med-
5 ical assistance under the State plan under title XIX of
6 the Social Security Act or enrolled in a child health plan
7 under title XXI of such Act shall have the right to be
8 paid directly by the State agency administering such plans
9 notwithstanding any agreements the State may have en-
10 tered into with managed care organizations or providers.

11 “(f) REQUIREMENT FOR MEDICAID MANAGED CARE
12 ENTITIES.—A managed care entity (as defined in section
13 1932(a)(1)(B) of the Social Security Act shall, as a condi-
14 tion of participation in the State plan under title XIX of
15 such Act, offer a contract to health programs administered
16 by the Service, an Indian tribe or tribal organization or
17 an urban Indian organization that provides health services
18 in the geographic area served by the managed care entity
19 and such contract (or other provider participation agree-
20 ment) shall contain terms and conditions of participation
21 and payment no more restrictive or onerous than those
22 provided for in this section.

23 “(g) PROHIBITION.—Notwithstanding any other pro-
24 vision of law or any waiver granted by the Secretary no
25 Indian may be assigned automatically or by default under

1 any managed care entity participating in a State plan
2 under title XIX or XXI of the Social Security Act unless
3 the Indian had the option of enrolling in a managed care
4 plan or health program administered by the Service, an
5 Indian tribe or tribal organization, or an urban Indian or-
6 ganization.

7 “(h) INDIAN MANAGED CARE PLANS.—Notwith-
8 standing any other provision of law, any State entering
9 into agreements with one or more managed care organiza-
10 tions to provide services under title XIX or XXI of the
11 Social Security Act shall enter into such an agreement
12 with the Service, an Indian tribe or tribal organization or
13 an urban Indian organization under which such an entity
14 may provide services to Indians who may be eligible or
15 required to enroll with a managed care organization
16 through enrollment in an Indian managed care organiza-
17 tion that provides services similar to those offered by other
18 managed care organizations in the State. The Secretary
19 and the State are hereby authorized to waive requirements
20 regarding discrimination, capitalization, and other matters
21 that might otherwise prevent an Indian managed care or-
22 ganization or health program from meeting Federal or
23 State standards applicable to such organizations, provided
24 such Indian managed care organization or health program

1 offers Indian enrollees services of an equivalent quality to
2 that required of other managed care organizations.

3 “(i) ADVERTISING.—A managed care organization
4 entering into a contract to provide services to Indians on
5 or near an Indian reservation shall provide a certificate
6 of coverage or similar type of document that is written
7 in the Indian language of the majority of the Indian popu-
8 lation residing on such reservation.

9 **“SEC. 424. NAVAJO NATION MEDICAID AGENCY.**

10 “(a) IN GENERAL.—Notwithstanding any other pro-
11 vision of law, the Secretary may treat the Navajo Nation
12 as a State under title XIX of the Social Security Act for
13 purposes of providing medical assistance to Indians living
14 within the boundaries of the Navajo Nation.

15 “(b) ASSIGNMENT AND PAYMENT.—Notwithstanding
16 any other provision of law, the Secretary may assign and
17 pay all expenditures related to the provision of services
18 to Indians living within the boundaries of the Navajo Na-
19 tion under title XIX of the Social Security Act (including
20 administrative expenditures) that are currently paid to or
21 would otherwise be paid to the States of Arizona, New
22 Mexico, and Utah, to an entity established by the Navajo
23 Nation and approved by the Secretary, which shall be de-
24 nominated the Navajo Nation Medicaid Agency.

1 “(c) AUTHORITY.—The Navajo Nation Medicaid
2 Agency shall serve Indians living within the boundaries of
3 the Navajo Nation and shall have the same authority and
4 perform the same functions as other State agency respon-
5 sible for the administration of the State plan under title
6 XIX of the Social Security Act.

7 “(d) TECHNICAL ASSISTANCE.—The Secretary may
8 directly assist the Navajo Nation in the development and
9 implementation of a Navajo Nation Medicaid Agency for
10 the administration, eligibility, payment, and delivery of
11 medical assistance under title XIX of the Social Security
12 Act (which shall, for purposes of reimbursement to such
13 Nation, include Western and traditional Navajo healing
14 services) within the Navajo Nation. Such assistance may
15 include providing funds for demonstration projects con-
16 ducted with such Nation.

17 “(e) FMAP.—Notwithstanding section 1905(b) of
18 the Social Security Act, the Federal medical assistance
19 percentage shall be 100 per cent with respect to amounts
20 the Navajo Nation Medicaid agency expends for medical
21 assistance and related administrative costs.

22 “(f) WAIVER AUTHORITY.—The Secretary shall have
23 the authority to waive applicable provisions of title XIX
24 of the Social Security Act to establish, develop and imple-
25 ment the Navajo Nation Medicaid Agency.

1 “(g) SCHIP.—At the option of the Navajo Nation,
 2 the Secretary may treat the Navajo Nation as a State for
 3 purposes of title XXI of the Social Security Act under
 4 terms equivalent to those described in the preceding sub-
 5 sections of this section.

6 **“SEC. 425. INDIAN ADVISORY COMMITTEES.**

7 “(a) NATIONAL INDIAN TECHNICAL ADVISORY
 8 GROUP.—The Administrator of the Health Care Financ-
 9 ing Administration shall establish and fund the expenses
 10 of a National Indian Technical Advisory Group which shall
 11 have no fewer than 14 members, including at least 1 mem-
 12 ber designated by the Indian tribes and tribal organiza-
 13 tions in each service area, 1 urban Indian organization
 14 representative, and 1 member representing the Service.
 15 The scope of the activities of such group shall be estab-
 16 lished under section 802 provided that such scope shall
 17 include providing comment on and advice regarding the
 18 programs funded under titles XVIII, XIX, and XXI of the
 19 Social Security Act or regarding any other health care pro-
 20 gram funded (in whole or part) by the Health Care Fi-
 21 nancing Administration.

22 “(b) INDIAN MEDICAID ADVISORY COMMITTEES.—
 23 The Administrator of the Health Care Financing Adminis-
 24 tration shall establish and provide funding for a Indian
 25 Medicaid Advisory Committee made up of designees of the

1 Service, Indian tribes and tribal organizations and urban
 2 Indian organizations in each State in which the Service
 3 directly operates a health program or in which there is
 4 one or more Indian tribe or tribal organization or urban
 5 Indian organization.

6 **“SEC. 426. AUTHORIZATION OF APPROPRIATIONS.**

7 There is authorized to be appropriated such sums as
 8 may be necessary for each of fiscal years 2004 through
 9 2015 to carry out this title.”.

10 **“TITLE V—HEALTH SERVICES**
 11 **FOR URBAN INDIANS**

12 **“SEC. 501. PURPOSE.**

13 “The purpose of this title is to establish programs
 14 in urban centers to make health services more accessible
 15 and available to urban Indians.

16 **“SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN IN-**
 17 **DIAN ORGANIZATIONS.**

18 “Under the authority of the Act of November 2, 1921
 19 (25 U.S.C. 13) (commonly known as the Snyder Act), the
 20 Secretary, through the Service, shall enter into contracts
 21 with, or make grants to, urban Indian organizations to
 22 assist such organizations in the establishment and admin-
 23 istration, within urban centers, of programs which meet
 24 the requirements set forth in this title. The Secretary,
 25 through the Service, subject to section 506, shall include

1 such conditions as the Secretary considers necessary to ef-
 2 feet the purpose of this title in any contract which the
 3 Secretary enters into with, or in any grant the Secretary
 4 makes to, any urban Indian organization pursuant to this
 5 title.

6 **“SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION**
 7 **OF HEALTH CARE AND REFERRAL SERVICES.**

8 “(a) AUTHORITY.—Under the authority of the Act of
 9 November 2, 1921 (25 U.S.C. 13) (commonly known as
 10 the Snyder Act), the Secretary, acting through the Serv-
 11 ice, shall enter into contracts with, and make grants to,
 12 urban Indian organizations for the provision of health care
 13 and referral services for urban Indians. Any such contract
 14 or grant shall include requirements that the urban Indian
 15 organization successfully undertake to—

16 “(1) estimate the population of urban Indians
 17 residing in the urban center or centers that the or-
 18 ganization proposes to serve who are or could be re-
 19 cipients of health care or referral services;

20 “(2) estimate the current health status of
 21 urban Indians residing in such urban center or cen-
 22 ters;

23 “(3) estimate the current health care needs of
 24 urban Indians residing in such urban center or cen-
 25 ters;

1 “(4) provide basic health education, including
2 health promotion and disease prevention education,
3 to urban Indians;

4 “(5) make recommendations to the Secretary
5 and Federal, State, local, and other resource agen-
6 cies on methods of improving health service pro-
7 grams to meet the needs of urban Indians; and

8 “(6) where necessary, provide, or enter into
9 contracts for the provision of, health care services
10 for urban Indians.

11 “(b) CRITERIA.—The Secretary, acting through the
12 Service, shall by regulation adopted pursuant to section
13 520 prescribe the criteria for selecting urban Indian orga-
14 nizations to enter into contracts or receive grants under
15 this section. Such criteria shall, among other factors,
16 include—

17 “(1) the extent of unmet health care needs of
18 urban Indians in the urban center or centers in-
19 volved;

20 “(2) the size of the urban Indian population in
21 the urban center or centers involved;

22 “(3) the extent, if any, to which the activities
23 set forth in subsection (a) would duplicate any
24 project funded under this title;

1 “(4) the capability of an urban Indian organiza-
2 tion to perform the activities set forth in subsection
3 (a) and to enter into a contract with the Secretary
4 or to meet the requirements for receiving a grant
5 under this section;

6 “(5) the satisfactory performance and success-
7 ful completion by an urban Indian organization of
8 other contracts with the Secretary under this title;

9 “(6) the appropriateness and likely effectiveness
10 of conducting the activities set forth in subsection
11 (a) in an urban center or centers; and

12 “(7) the extent of existing or likely future par-
13 ticipation in the activities set forth in subsection (a)
14 by appropriate health and health-related Federal,
15 State, local, and other agencies.

16 “(c) HEALTH PROMOTION AND DISEASE PREVEN-
17 TION.—The Secretary, acting through the Service, shall
18 facilitate access to, or provide, health promotion and dis-
19 ease prevention services for urban Indians through grants
20 made to urban Indian organizations administering con-
21 tracts entered into pursuant to this section or receiving
22 grants under subsection (a).

23 “(d) IMMUNIZATION SERVICES.—

24 “(1) IN GENERAL.—The Secretary, acting
25 through the Service, shall facilitate access to, or pro-

1 vide, immunization services for urban Indians
2 through grants made to urban Indian organizations
3 administering contracts entered into, or receiving
4 grants, under this section.

5 “(2) DEFINITION.—In this section, the term
6 ‘immunization services’ means services to provide
7 without charge immunizations against vaccine-pre-
8 ventable diseases.

9 “(e) MENTAL HEALTH SERVICES.—

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

16 “(2) ASSESSMENT.—A grant may not be made
17 under this subsection to an urban Indian organiza-
18 tion until that organization has prepared, and the
19 Service has approved, an assessment of the mental
20 health needs of the urban Indian population con-
21 cerned, the mental health services and other related
22 resources available to that population, the barriers
23 to obtaining those services and resources, and the
24 needs that are unmet by such services and resources.

1 “(3) USE OF FUNDS.—Grants may be made
2 under this subsection—

3 “(A) to prepare assessments required
4 under paragraph (2);

5 “(B) to provide outreach, educational, and
6 referral services to urban Indians regarding the
7 availability of direct behavioral health services,
8 to educate urban Indians about behavioral
9 health issues and services, and effect coordina-
10 tion with existing behavioral health providers in
11 order to improve services to urban Indians;

12 “(C) to provide outpatient behavioral
13 health services to urban Indians, including the
14 identification and assessment of illness, thera-
15 peutic treatments, case management, support
16 groups, family treatment, and other treatment;
17 and

18 “(D) to develop innovative behavioral
19 health service delivery models which incorporate
20 Indian cultural support systems and resources.

21 “(f) CHILD ABUSE.—

22 “(1) IN GENERAL.—The Secretary, acting
23 through the Service, shall facilitate access to, or pro-
24 vide, services for urban Indians through grants to
25 urban Indian organizations administering contracts

1 entered into pursuant to this section or receiving
2 grants under subsection (a) to prevent and treat
3 child abuse (including sexual abuse) among urban
4 Indians.

5 “(2) ASSESSMENT.—A grant may not be made
6 under this subsection to an urban Indian organiza-
7 tion until that organization has prepared, and the
8 Service has approved, an assessment that documents
9 the prevalence of child abuse in the urban Indian
10 population concerned and specifies the services and
11 programs (which may not duplicate existing services
12 and programs) for which the grant is requested.

13 “(3) USE OF FUNDS.—Grants may be made
14 under this subsection—

15 “(A) to prepare assessments required
16 under paragraph (2);

17 “(B) for the development of prevention,
18 training, and education programs for urban In-
19 dian populations, including child education, par-
20 ent education, provider training on identifica-
21 tion and intervention, education on reporting
22 requirements, prevention campaigns, and estab-
23 lishing service networks of all those involved in
24 Indian child protection; and

1 “(C) to provide direct outpatient treatment
2 services (including individual treatment, family
3 treatment, group therapy, and support groups)
4 to urban Indians who are child victims of abuse
5 (including sexual abuse) or adult survivors of
6 child sexual abuse, to the families of such child
7 victims, and to urban Indian perpetrators of
8 child abuse (including sexual abuse).

9 “(4) CONSIDERATIONS.—In making grants to
10 carry out this subsection, the Secretary shall take
11 into consideration—

12 “(A) the support for the urban Indian or-
13 ganization demonstrated by the child protection
14 authorities in the area, including committees or
15 other services funded under the Indian Child
16 Welfare Act of 1978 (25 U.S.C. 1901 et seq.),
17 if any;

18 “(B) the capability and expertise dem-
19 onstrated by the urban Indian organization to
20 address the complex problem of child sexual
21 abuse in the community; and

22 “(C) the assessment required under para-
23 graph (2).

24 “(g) MULTIPLE URBAN CENTERS.—The Secretary,
25 acting through the Service, may enter into a contract with,

1 or make grants to, an urban Indian organization that pro-
 2 vides or arranges for the provision of health care services
 3 (through satellite facilities, provider networks, or other-
 4 wise) to urban Indians in more than one urban center.

5 **“SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINA-**
 6 **TION OF UNMET HEALTH CARE NEEDS.**

7 “(a) AUTHORITY.—

8 “(1) IN GENERAL.—Under authority of the Act
 9 of November 2, 1921 (25 U.S.C. 13) (commonly
 10 known as the Snyder Act), the Secretary, acting
 11 through the Service, may enter into contracts with,
 12 or make grants to, urban Indian organizations situ-
 13 ated in urban centers for which contracts have not
 14 been entered into, or grants have not been made,
 15 under section 503.

16 “(2) PURPOSE.—The purpose of a contract or
 17 grant made under this section shall be the deter-
 18 mination of the matters described in subsection
 19 (b)(1) in order to assist the Secretary in assessing
 20 the health status and health care needs of urban In-
 21 dians in the urban center involved and determining
 22 whether the Secretary should enter into a contract
 23 or make a grant under section 503 with respect to
 24 the urban Indian organization which the Secretary

1 has entered into a contract with, or made a grant
2 to, under this section.

3 “(b) REQUIREMENTS.—Any contract entered into, or
4 grant made, by the Secretary under this section shall in-
5 clude requirements that—

6 “(1) the urban Indian organization successfully
7 undertake to—

8 “(A) document the health care status and
9 unmet health care needs of urban Indians in
10 the urban center involved; and

11 “(B) with respect to urban Indians in the
12 urban center involved, determine the matters
13 described in paragraphs (2), (3), (4), and (7) of
14 section 503(b); and

15 “(2) the urban Indian organization complete
16 performance of the contract, or carry out the re-
17 quirements of the grant, within 1 year after the date
18 on which the Secretary and such organization enter
19 into such contract, or within 1 year after such orga-
20 nization receives such grant, whichever is applicable.

21 “(c) LIMITATION ON RENEWAL.—The Secretary may
22 not renew any contract entered into, or grant made, under
23 this section.

1 **“SEC. 505. EVALUATIONS; RENEWALS.**

2 “(a) PROCEDURES.—The Secretary, acting through
3 the Service, shall develop procedures to evaluate compli-
4 ance with grant requirements under this title and compli-
5 ance with, and performance of contracts entered into by
6 urban Indian organizations under this title. Such proce-
7 dures shall include provisions for carrying out the require-
8 ments of this section.

9 “(b) COMPLIANCE WITH TERMS.—The Secretary,
10 acting through the Service, shall evaluate the compliance
11 of each urban Indian organization which has entered into
12 a contract or received a grant under section 503 with the
13 terms of such contract or grant. For purposes of an eval-
14 uation under this subsection, the Secretary, in determin-
15 ing the capacity of an urban Indian organization to deliver
16 quality patient care shall, at the option of the
17 organization—

18 “(1) conduct, through the Service, an annual
19 onsite evaluation of the organization; or

20 “(2) accept, in lieu of an onsite evaluation, evi-
21 dence of the organization’s provisional or full accred-
22 itation by a private independent entity recognized by
23 the Secretary for purposes of conducting quality re-
24 views of providers participating in the medicare pro-
25 gram under Title XVIII of the Social Security Act.

26 “(c) NONCOMPLIANCE.—

1 “(1) IN GENERAL.—If, as a result of the eval-
2 uations conducted under this section, the Secretary
3 determines that an urban Indian organization has
4 not complied with the requirements of a grant or
5 complied with or satisfactorily performed a contract
6 under section 503, the Secretary shall, prior to re-
7 newing such contract or grant, attempt to resolve
8 with such organization the areas of noncompliance
9 or unsatisfactory performance and modify such con-
10 tract or grant to prevent future occurrences of such
11 noncompliance or unsatisfactory performance.

12 “(2) NONRENEWAL.—If the Secretary deter-
13 mines, under an evaluation under this section, that
14 noncompliance or unsatisfactory performance cannot
15 be resolved and prevented in the future, the Sec-
16 retary shall not renew such contract or grant with
17 such organization and is authorized to enter into a
18 contract or make a grant under section 503 with an-
19 other urban Indian organization which is situated in
20 the same urban center as the urban Indian organiza-
21 tion whose contract or grant is not renewed under
22 this section.

23 “(d) DETERMINATION OF RENEWAL.—In determin-
24 ing whether to renew a contract or grant with an urban
25 Indian organization under section 503 which has com-

1 pleted performance of a contract or grant under section
2 504, the Secretary shall review the records of the urban
3 Indian organization, the reports submitted under section
4 507, and, in the case of a renewal of a contract or grant
5 under section 503, shall consider the results of the onsite
6 evaluations or accreditation under subsection (b).

7 **“SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.**

8 “(a) APPLICATION OF FEDERAL LAW.—Contracts
9 with urban Indian organizations entered into pursuant to
10 this title shall be in accordance with all Federal contract-
11 ing laws and regulations relating to procurement except
12 that, in the discretion of the Secretary, such contracts may
13 be negotiated without advertising and need not conform
14 to the provisions of the Act of August 24, 1935 (40 U.S.C.
15 270a, et seq.).

16 “(b) PAYMENTS.—Payments under any contracts or
17 grants pursuant to this title shall, notwithstanding any
18 term or condition of such contract or grant—

19 “(1) be made in their entirety by the Secretary
20 to the urban Indian organization by not later than
21 the end of the first 30 days of the funding period
22 with respect to which the payments apply, unless the
23 Secretary determines through an evaluation under
24 section 505 that the organization is not capable of
25 administering such payments in their entirety; and

1 “(2) if unexpended by the urban Indian organi-
2 zation during the funding period with respect to
3 which the payments initially apply, be carried for-
4 ward for expenditure with respect to allowable or re-
5 imbursable costs incurred by the organization during
6 1 or more subsequent funding periods without addi-
7 tional justification or documentation by the organi-
8 zation as a condition of carrying forward the ex-
9 penditure of such funds.

10 “(c) REVISING OR AMENDING CONTRACT.—Notwith-
11 standing any provision of law to the contrary, the Sec-
12 retary may, at the request or consent of an urban Indian
13 organization, revise or amend any contract entered into
14 by the Secretary with such organization under this title
15 as necessary to carry out the purposes of this title.

16 “(d) FAIR AND UNIFORM PROVISION OF SERV-
17 ICES.—Contracts with, or grants to, urban Indian organi-
18 zations and regulations adopted pursuant to this title shall
19 include provisions to assure the fair and uniform provision
20 to urban Indians of services and assistance under such
21 contracts or grants by such organizations.

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

1 **“SEC. 507. REPORTS AND RECORDS.**

2 “(a) REPORT.—For each fiscal year during which an
3 urban Indian organization receives or expends funds pur-
4 suant to a contract entered into, or a grant received, pur-
5 suant to this title, such organization shall submit to the
6 Secretary, on a basis no more frequent than every 6
7 months, a report including—

8 “(1) in the case of a contract or grant under
9 section 503, information gathered pursuant to para-
10 graph (5) of subsection (a) of such section;

11 “(2) information on activities conducted by the
12 organization pursuant to the contract or grant;

13 “(3) an accounting of the amounts and pur-
14 poses for which Federal funds were expended; and

15 “(4) a minimum set of data, using uniformly
16 defined elements, that is specified by the Secretary,
17 after consultations consistent with section 514, with
18 urban Indian organizations.

19 “(b) AUDITS.—The reports and records of the urban
20 Indian organization with respect to a contract or grant
21 under this title shall be subject to audit by the Secretary
22 and the Comptroller General of the United States.

23 “(c) COST OF AUDIT.—The Secretary shall allow as
24 a cost of any contract or grant entered into or awarded
25 under section 502 or 503 the cost of an annual independ-
26 ent financial audit conducted by—

1 “(1) a certified public accountant; or

2 “(2) a certified public accounting firm qualified
3 to conduct Federal compliance audits.

4 **“SEC. 508. LIMITATION ON CONTRACT AUTHORITY.**

5 “The authority of the Secretary to enter into con-
6 tracts or to award grants under this title shall be to the
7 extent, and in an amount, provided for in appropriation
8 Acts.

9 **“SEC. 509. FACILITIES.**

10 “(a) GRANTS.—The Secretary may make grants to
11 contractors or grant recipients under this title for the
12 lease, purchase, renovation, construction, or expansion of
13 facilities, including leased facilities, in order to assist such
14 contractors or grant recipients in complying with applica-
15 ble licensure or certification requirements.

16 “(b) LOANS OR LOAN GUARANTEES.—The Secretary,
17 acting through the Service or through the Health Re-
18 sources and Services Administration, may provide loans
19 to contractors or grant recipients under this title from the
20 Urban Indian Health Care Facilities Revolving Loan
21 Fund (referred to in this section as the ‘URLF’) described
22 in subsection (c), or guarantees for loans, for the construc-
23 tion, renovation, expansion, or purchase of health care fa-
24 cilities, subject to the following requirements:

1 “(1) The principal amount of a loan or loan
2 guarantee may cover 100 percent of the costs (other
3 than staffing) relating to the facility, including plan-
4 ning, design, financing, site land development, con-
5 struction, rehabilitation, renovation, conversion,
6 medical equipment, furnishings, and capital pur-
7 chase.

8 “(2) The total amount of the principal of loans
9 and loan guarantees, respectively, outstanding at
10 any one time shall not exceed such limitations as
11 may be specified in appropriations Acts.

12 “(3) The loan or loan guarantee may have a
13 term of the shorter of the estimated useful life of the
14 facility, or 25 years.

15 “(4) An urban Indian organization may assign,
16 and the Secretary may accept assignment of, the
17 revenue of the organization as security for a loan or
18 loan guarantee under this subsection.

19 “(5) The Secretary shall not collect application,
20 processing, or similar fees from urban Indian organi-
21 zations applying for loans or loan guarantees under
22 this subsection.

23 “(c) URBAN INDIAN HEALTH CARE FACILITIES RE-
24 VOLVING LOAN FUND.—

1 “(1) ESTABLISHMENT.—There is established in
2 the Treasury of the United States a fund to be
3 known as the Urban Indian Health Care Facilities
4 Revolving Loan Fund. The URLF shall consist of—

5 “(A) such amounts as may be appropriated
6 to the URLF;

7 “(B) amounts received from urban Indian
8 organizations in repayment of loans made to
9 such organizations under paragraph (2); and

10 “(C) interest earned on amounts in the
11 URLF under paragraph (3).

12 “(2) USE OF URLF.—Amounts in the URLF
13 may be expended by the Secretary, acting through
14 the Service or the Health Resources and Services
15 Administration, to make loans available to urban In-
16 dian organizations receiving grants or contracts
17 under this title for the purposes, and subject to the
18 requirements, described in subsection (b). Amounts
19 appropriated to the URLF, amounts received from
20 urban Indian organizations in repayment of loans,
21 and interest on amounts in the URLF shall remain
22 available until expended.

23 “(3) INVESTMENTS.—The Secretary of the
24 Treasury shall invest such amounts of the URLF as
25 such Secretary determines are not required to meet

1 current withdrawals from the URLF. Such invest-
2 ments may be made only in interest-bearing obliga-
3 tions of the United States. For such purpose, such
4 obligations may be acquired on original issue at the
5 issue price, or by purchase of outstanding obliga-
6 tions at the market price. Any obligation acquired by
7 the URLF may be sold by the Secretary of the
8 Treasury at the market price.

9 **“SEC. 510. OFFICE OF URBAN INDIAN HEALTH.**

10 “There is hereby established within the Service an
11 Office of Urban Indian Health which shall be responsible
12 for—

13 “(1) carrying out the provisions of this title;

14 “(2) providing central oversight of the pro-
15 grams and services authorized under this title; and

16 “(3) providing technical assistance to urban In-
17 dian organizations.

18 **“SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE**
19 **RELATED SERVICES.**

20 “(a) GRANTS.—The Secretary may make grants for
21 the provision of health-related services in prevention of,
22 treatment of, rehabilitation of, or school and community-
23 based education in, alcohol and substance abuse in urban
24 centers to those urban Indian organizations with whom

1 the Secretary has entered into a contract under this title
2 or under section 201.

3 “(b) GOALS OF GRANT.—Each grant made pursuant
4 to subsection (a) shall set forth the goals to be accom-
5 plished pursuant to the grant. The goals shall be specific
6 to each grant as agreed to between the Secretary and the
7 grantee.

8 “(c) CRITERIA.—The Secretary shall establish cri-
9 teria for the grants made under subsection (a), including
10 criteria relating to the—

11 “(1) size of the urban Indian population;

12 “(2) capability of the organization to adequately
13 perform the activities required under the grant;

14 “(3) satisfactory performance standards for the
15 organization in meeting the goals set forth in such
16 grant, which standards shall be negotiated and
17 agreed to between the Secretary and the grantee on
18 a grant-by-grant basis; and

19 “(4) identification of need for services.

20 The Secretary shall develop a methodology for allocating
21 grants made pursuant to this section based on such cri-
22 teria.

23 “(d) TREATMENT OF FUNDS RECEIVED BY URBAN
24 INDIAN ORGANIZATIONS.—Any funds received by an
25 urban Indian organization under this Act for substance

1 abuse prevention, treatment, and rehabilitation shall be
2 subject to the criteria set forth in subsection (c).

3 **“SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION**
4 **PROJECTS.**

5 “(a) TULSA AND OKLAHOMA CITY CLINICS.—Not-
6 withstanding any other provision of law, the Tulsa and
7 Oklahoma City Clinic demonstration projects shall become
8 permanent programs within the Service’s direct care pro-
9 gram and continue to be treated as service units in the
10 allocation of resources and coordination of care, and shall
11 continue to meet the requirements and definitions of an
12 urban Indian organization in this title, and as such will
13 not be subject to the provisions of the Indian Self-Deter-
14 mination and Education Assistance Act.

15 “(b) REPORT.—The Secretary shall submit to the
16 President, for inclusion in the report required to be sub-
17 mitted to the Congress under section 801 for fiscal year
18 1999, a report on the findings and conclusions derived
19 from the demonstration projects specified in subsection
20 (a).

21 **“SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.**

22 “(a) GRANTS AND CONTRACTS.—The Secretary, act-
23 ing through the Office of Urban Indian Health of the
24 Service, shall make grants or enter into contracts, effective
25 not later than September 30, 2004, with urban Indian or-

1 ganizations for the administration of urban Indian alcohol
 2 programs that were originally established under the Na-
 3 tional Institute on Alcoholism and Alcohol Abuse (referred
 4 to in this section to as ‘NIAAA’) and transferred to the
 5 Service.

6 “(b) USE OF FUNDS.—Grants provided or contracts
 7 entered into under this section shall be used to provide
 8 support for the continuation of alcohol prevention and
 9 treatment services for urban Indian populations and such
 10 other objectives as are agreed upon between the Service
 11 and a recipient of a grant or contract under this section.

12 “(c) ELIGIBILITY.—Urban Indian organizations that
 13 operate Indian alcohol programs originally funded under
 14 NIAAA and subsequently transferred to the Service are
 15 eligible for grants or contracts under this section.

16 “(d) EVALUATION AND REPORT.—The Secretary
 17 shall evaluate and report to the Congress on the activities
 18 of programs funded under this section at least every 5
 19 years.

20 **“SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZA-**
 21 **TIONS.**

22 “(a) IN GENERAL.—The Secretary shall ensure that
 23 the Service, the Health Care Financing Administration,
 24 and other operating divisions and staff divisions of the De-
 25 partment consult, to the maximum extent practicable, with

1 urban Indian organizations (as defined in section 4) prior
2 to taking any action, or approving Federal financial assist-
3 ance for any action of a State, that may affect urban Indi-
4 ans or urban Indian organizations.

5 “(b) REQUIREMENT.—In subsection (a), the term
6 ‘consultation’ means the open and free exchange of infor-
7 mation and opinion among urban Indian organizations
8 and the operating and staff divisions of the Department
9 which leads to mutual understanding and comprehension
10 and which emphasizes trust, respect, and shared respon-
11 sibility.

12 **“SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.**

13 “For purposes of section 224 of the Public Health
14 Service Act (42 U.S.C. 233), with respect to claims by
15 any person, initially filed on or after October 1, 1999,
16 whether or not such person is an Indian or Alaska Native
17 or is served on a fee basis or under other circumstances
18 as permitted by Federal law or regulations, for personal
19 injury (including death) resulting from the performance
20 prior to, including, or after October 1, 1999, of medical,
21 surgical, dental, or related functions, including the con-
22 duct of clinical studies or investigations, or for purposes
23 of section 2679 of title 28, United States Code, with re-
24 spect to claims by any such person, on or after October
25 1, 1999, for personal injury (including death) resulting

1 from the operation of an emergency motor vehicle, an
2 urban Indian organization that has entered into a contract
3 or received a grant pursuant to this title is deemed to be
4 part of the Public Health Service while carrying out any
5 such contract or grant and its employees (including those
6 acting on behalf of the organization as provided for in sec-
7 tion 2671 of title 28, United States Code, and including
8 an individual who provides health care services pursuant
9 to a personal services contract with an urban Indian orga-
10 nization for the provision of services in any facility owned,
11 operated, or constructed under the jurisdiction of the In-
12 dian Health Service) are deemed employees of the Service
13 while acting within the scope of their employment in carry-
14 ing out the contract or grant, except that such employees
15 shall be deemed to be acting within the scope of their em-
16 ployment in carrying out the contract or grant when they
17 are required, by reason of their employment, to perform
18 medical, surgical, dental or related functions at a facility
19 other than a facility operated by the urban Indian organi-
20 zation pursuant to such contract or grant, but only if such
21 employees are not compensated for the performance of
22 such functions by a person or entity other than the urban
23 Indian organization.

1 **“SEC. 516. URBAN YOUTH TREATMENT CENTER DEM-**
2 **ONSTRATION.**

3 “(a) CONSTRUCTION AND OPERATION.—The Sec-
4 retary, acting through the Service, shall, through grants
5 or contracts, make payment for the construction and oper-
6 ation of at least 2 residential treatment centers in each
7 State described in subsection (b) to demonstrate the provi-
8 sion of alcohol and substance abuse treatment services to
9 urban Indian youth in a culturally competent residential
10 setting.

11 “(b) STATES.—A State described in this subsection
12 is a State in which—

13 “(1) there reside urban Indian youth with a
14 need for alcohol and substance abuse treatment serv-
15 ices in a residential setting; and

16 “(2) there is a significant shortage of culturally
17 competent residential treatment services for urban
18 Indian youth.

19 **“SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND**
20 **SOURCES OF SUPPLY.**

21 “(a) IN GENERAL.—The Secretary shall permit an
22 urban Indian organization that has entered into a contract
23 or received a grant pursuant to this title, in carrying out
24 such contract or grant, to use existing facilities and all
25 equipment therein or pertaining thereto and other per-
26 sonal property owned by the Federal Government within

1 the Secretary's jurisdiction under such terms and condi-
2 tions as may be agreed upon for their use and mainte-
3 nance.

4 “(b) DONATION OF PROPERTY.—Subject to sub-
5 section (d), the Secretary may donate to an urban Indian
6 organization that has entered into a contract or received
7 a grant pursuant to this title any personal or real property
8 determined to be excess to the needs of the Service or the
9 General Services Administration for purposes of carrying
10 out the contract or grant.

11 “(c) ACQUISITION OF PROPERTY.—The Secretary
12 may acquire excess or surplus government personal or real
13 property for donation, subject to subsection (d), to an
14 urban Indian organization that has entered into a contract
15 or received a grant pursuant to this title if the Secretary
16 determines that the property is appropriate for use by the
17 urban Indian organization for a purpose for which a con-
18 tract or grant is authorized under this title.

19 “(d) PRIORITY.—In the event that the Secretary re-
20 ceives a request for a specific item of personal or real
21 property described in subsections (b) or (c) from an urban
22 Indian organization and from an Indian tribe or tribal or-
23 ganization, the Secretary shall give priority to the request
24 for donation to the Indian tribe or tribal organization if
25 the Secretary receives the request from the Indian tribe

1 or tribal organization before the date on which the Sec-
2 retary transfers title to the property or, if earlier, the date
3 on which the Secretary transfers the property physically,
4 to the urban Indian organization.

5 “(e) RELATION TO FEDERAL SOURCES OF SUP-
6 PLY.—For purposes of section 201(a) of the Federal
7 Property and Administrative Services Act of 1949 (40
8 U.S.C. 481(a)) (relating to Federal sources of supply, in-
9 cluding lodging providers, airlines, and other transpor-
10 tation providers), an urban Indian organization that has
11 entered into a contract or received a grant pursuant to
12 this title shall be deemed an executive agency when carry-
13 ing out such contract or grant, and the employees of the
14 urban Indian organization shall be eligible to have access
15 to such sources of supply on the same basis as employees
16 of an executive agency have such access.

17 **“SEC. 518. GRANTS FOR DIABETES PREVENTION, TREAT-**
18 **MENT AND CONTROL.**

19 “(a) AUTHORITY.—The Secretary may make grants
20 to those urban Indian organizations that have entered into
21 a contract or have received a grant under this title for
22 the provision of services for the prevention, treatment, and
23 control of the complications resulting from, diabetes
24 among urban Indians.

1 “(b) GOALS.—Each grant made pursuant to sub-
2 section (a) shall set forth the goals to be accomplished
3 under the grant. The goals shall be specific to each grant
4 as agreed upon between the Secretary and the grantee.

5 “(c) CRITERIA.—The Secretary shall establish cri-
6 teria for the awarding of grants made under subsection
7 (a) relating to—

8 “(1) the size and location of the urban Indian
9 population to be served;

10 “(2) the need for the prevention of, treatment
11 of, and control of the complications resulting from
12 diabetes among the urban Indian population to be
13 served;

14 “(3) performance standards for the urban In-
15 dian organization in meeting the goals set forth in
16 such grant that are negotiated and agreed to by the
17 Secretary and the grantee;

18 “(4) the capability of the urban Indian organi-
19 zation to adequately perform the activities required
20 under the grant; and

21 “(5) the willingness of the urban Indian organi-
22 zation to collaborate with the registry, if any, estab-
23 lished by the Secretary under section 204(e) in the
24 area office of the Service in which the organization
25 is located.

1 “(d) APPLICATION OF CRITERIA.—Any funds re-
2 ceived by an urban Indian organization under this Act for
3 the prevention, treatment, and control of diabetes among
4 urban Indians shall be subject to the criteria developed
5 by the Secretary under subsection (c).

6 **“SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.**

7 “The Secretary, acting through the Service, may
8 enter into contracts with, and make grants to, urban In-
9 dian organizations for the use of Indians trained as health
10 service providers through the Community Health Rep-
11 resentatives Program under section 107(b) in the provi-
12 sion of health care, health promotion, and disease preven-
13 tion services to urban Indians.

14 **“SEC. 520. REGULATIONS.**

15 “(a) EFFECT OF TITLE.—This title shall be effective
16 on the date of enactment of this Act regardless of whether
17 the Secretary has promulgated regulations implementing
18 this title.

19 “(b) PROMULGATION.—

20 “(1) IN GENERAL.—The Secretary may promul-
21 gate regulations to implement the provisions of this
22 title.

23 “(2) PUBLICATION.—Proposed regulations to
24 implement this title shall be published by the Sec-
25 retary in the Federal Register not later than 270

1 days after the date of enactment of this Act and
2 shall have a comment period of not less than 120
3 days.

4 “(3) EXPIRATION OF AUTHORITY.—The author-
5 ity to promulgate regulations under this title shall
6 expire on the date that is 18 months after the date
7 of enactment of this Act.

8 “(c) NEGOTIATED RULEMAKING COMMITTEE.—A ne-
9 gotiated rulemaking committee shall be established pursu-
10 ant to section 565 of title 5, United States Code, to carry
11 out this section and shall, in addition to Federal represent-
12 atives, have as the majority of its members representatives
13 of urban Indian organizations from each service area.

14 “(d) ADAPTION OF PROCEDURES.—The Secretary
15 shall adapt the negotiated rulemaking procedures to the
16 unique context of this Act.

17 **“SEC. 521. AUTHORIZATION OF APPROPRIATIONS.**

18 “There is authorized to be appropriated such sums
19 as may be necessary for each fiscal year through fiscal
20 year 2015 to carry out this title.

1 **“TITLE VI—ORGANIZATIONAL**
2 **IMPROVEMENTS**

3 **“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
4 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
5 **SERVICE.**

6 “(a) ESTABLISHMENT.—

7 “(1) IN GENERAL.—In order to more effectively
8 and efficiently carry out the responsibilities, authori-
9 ties, and functions of the United States to provide
10 health care services to Indians and Indian tribes, as
11 are or may be hereafter provided by Federal statute
12 or treaties, there is established within the Public
13 Health Service of the Department the Indian Health
14 Service.

15 “(2) ASSISTANT SECRETARY OF INDIAN
16 HEALTH.—The Service shall be administered by an
17 Assistance Secretary of Indian Health, who shall be
18 appointed by the President, by and with the advice
19 and consent of the Senate. The Assistant Secretary
20 shall report to the Secretary. Effective with respect
21 to an individual appointed by the President, by and
22 with the advice and consent of the Senate, after
23 January 1, 1993, the term of service of the Assist-
24 ant Secretary shall be 4 years. An Assistant Sec-
25 retary may serve more than 1 term.

1 “(b) AGENCY.—The Service shall be an agency within
2 the Public Health Service of the Department, and shall
3 not be an office, component, or unit of any other agency
4 of the Department.

5 “(c) FUNCTIONS AND DUTIES.—The Secretary shall
6 carry out through the Assistant Secretary of the Service—

7 “(1) all functions which were, on the day before
8 the date of enactment of the Indian Health Care
9 Amendments of 1988, carried out by or under the
10 direction of the individual serving as Director of the
11 Service on such day;

12 “(2) all functions of the Secretary relating to
13 the maintenance and operation of hospital and
14 health facilities for Indians and the planning for,
15 and provision and utilization of, health services for
16 Indians;

17 “(3) all health programs under which health
18 care is provided to Indians based upon their status
19 as Indians which are administered by the Secretary,
20 including programs under—

21 “(A) this Act;

22 “(B) the Act of November 2, 1921 (25
23 U.S.C. 13);

24 “(C) the Act of August 5, 1954 (42 U.S.C.
25 2001, et seq.);

1 “(D) the Act of August 16, 1957 (42
2 U.S.C. 2005 et seq.); and

3 “(E) the Indian Self-Determination Act
4 (25 U.S.C. 450f, et seq.); and

5 “(4) all scholarship and loan functions carried
6 out under title I.

7 “(d) AUTHORITY.—

8 “(1) IN GENERAL.—The Secretary, acting
9 through the Assistant Secretary, shall have the
10 authority—

11 “(A) except to the extent provided for in
12 paragraph (2), to appoint and compensate em-
13 ployees for the Service in accordance with title
14 5, United States Code;

15 “(B) to enter into contracts for the pro-
16 curement of goods and services to carry out the
17 functions of the Service; and

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

20 “(2) PERSONNEL ACTIONS.—Notwithstanding
21 any other provision of law, the provisions of section
22 12 of the Act of June 18, 1934 (48 Stat. 986; 25
23 U.S.C. 472), shall apply to all personnel actions
24 taken with respect to new positions created within

1 the Service as a result of its establishment under
2 subsection (a).

3 **“SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYS-**
4 **TEM.**

5 “(a) ESTABLISHMENT.—

6 “(1) IN GENERAL.—The Secretary, in consulta-
7 tion with tribes, tribal organizations, and urban In-
8 dian organizations, shall establish an automated
9 management information system for the Service.

10 “(2) REQUIREMENTS OF SYSTEM.—The infor-
11 mation system established under paragraph (1) shall
12 include—

13 “(A) a financial management system;

14 “(B) a patient care information system;

15 “(C) a privacy component that protects the
16 privacy of patient information;

17 “(D) a services-based cost accounting com-
18 ponent that provides estimates of the costs as-
19 sociated with the provision of specific medical
20 treatments or services in each area office of the
21 Service;

22 “(E) an interface mechanism for patient
23 billing and accounts receivable system; and

24 “(F) a training component.

1 “(b) PROVISION OF SYSTEMS TO TRIBES AND ORGA-
2 NIZATIONS.—The Secretary shall provide each Indian
3 tribe and tribal organization that provides health services
4 under a contract entered into with the Service under the
5 Indian Self-Determination Act automated management in-
6 formation systems which—

7 “(1) meet the management information needs
8 of such Indian tribe or tribal organization with re-
9 spect to the treatment by the Indian tribe or tribal
10 organization of patients of the Service; and

11 “(2) meet the management information needs
12 of the Service.

13 “(c) ACCESS TO RECORDS.—Notwithstanding any
14 other provision of law, each patient shall have reasonable
15 access to the medical or health records of such patient
16 which are held by, or on behalf of, the Service.

17 “(d) AUTHORITY TO ENHANCE INFORMATION TECH-
18 NOLOGY.—The Secretary, acting through the Assistant
19 Secretary, shall have the authority to enter into contracts,
20 agreements or joint ventures with other Federal agencies,
21 States, private and nonprofit organizations, for the pur-
22 pose of enhancing information technology in Indian health
23 programs and facilities.

1 **“SEC. 603. AUTHORIZATION OF APPROPRIATIONS.**

2 “There is authorized to be appropriated such sums
3 as may be necessary for each fiscal year through fiscal
4 year 2015 to carry out this title.

5 **“TITLE VII—BEHAVIORAL**
6 **HEALTH PROGRAMS**

7 **“SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREAT-**
8 **MENT SERVICES.**

9 “(a) PURPOSES.—It is the purpose of this section
10 to—

11 “(1) authorize and direct the Secretary, acting
12 through the Service, Indian tribes, tribal organiza-
13 tions, and urban Indian organizations to develop a
14 comprehensive behavioral health prevention and
15 treatment program which emphasizes collaboration
16 among alcohol and substance abuse, social services,
17 and mental health programs;

18 “(2) provide information, direction and guid-
19 ance relating to mental illness and dysfunction and
20 self-destructive behavior, including child abuse and
21 family violence, to those Federal, tribal, State and
22 local agencies responsible for programs in Indian
23 communities in areas of health care, education, so-
24 cial services, child and family welfare, alcohol and
25 substance abuse, law enforcement and judicial serv-
26 ices;

1 “(3) assist Indian tribes to identify services and
2 resources available to address mental illness and
3 dysfunctional and self-destructive behavior;

4 “(4) provide authority and opportunities for In-
5 dian tribes to develop and implement, and coordinate
6 with, community-based programs which include iden-
7 tification, prevention, education, referral, and treat-
8 ment services, including through multi-disciplinary
9 resource teams;

10 “(5) ensure that Indians, as citizens of the
11 United States and of the States in which they re-
12 side, have the same access to behavioral health serv-
13 ices to which all citizens have access; and

14 “(6) modify or supplement existing programs
15 and authorities in the areas identified in paragraph
16 (2).

17 “(b) BEHAVIORAL HEALTH PLANNING.—

18 “(1) AREA-WIDE PLANS.—The Secretary, acting
19 through the Service, Indian tribes, tribal organiza-
20 tions, and urban Indian organizations, shall encour-
21 age Indian tribes and tribal organizations to develop
22 tribal plans, encourage urban Indian organizations
23 to develop local plans, and encourage all such groups
24 to participate in developing area-wide plans for In-

1 dian Behavioral Health Services. The plans shall, to
2 the extent feasible, include—

3 “(A) an assessment of the scope of the
4 problem of alcohol or other substance abuse,
5 mental illness, dysfunctional and self-destructive
6 behavior, including suicide, child abuse and
7 family violence, among Indians, including—

8 “(i) the number of Indians served who
9 are directly or indirectly affected by such
10 illness or behavior; and

11 “(ii) an estimate of the financial and
12 human cost attributable to such illness or
13 behavior;

14 “(B) an assessment of the existing and additional
15 resources necessary for the prevention
16 and treatment of such illness and behavior, including
17 an assessment of the progress toward
18 achieving the availability of the full continuum
19 of care described in subsection (c); and

20 “(C) an estimate of the additional funding
21 needed by the Service, Indian tribes, tribal organizations
22 and urban Indian organizations to
23 meet their responsibilities under the plans.

24 “(2) NATIONAL CLEARINGHOUSE.—The Secretary
25 shall establish a national clearinghouse of

1 plans and reports on the outcomes of such plans de-
2 veloped under this section by Indian tribes, tribal or-
3 ganizations and by areas relating to behavioral
4 health. The Secretary shall ensure access to such
5 plans and outcomes by any Indian tribe, tribal orga-
6 nization, urban Indian organization or the Service.

7 “(3) TECHNICAL ASSISTANCE.—The Secretary
8 shall provide technical assistance to Indian tribes,
9 tribal organizations, and urban Indian organizations
10 in preparation of plans under this section and in de-
11 veloping standards of care that may be utilized and
12 adopted locally.

13 “(c) CONTINUUM OF CARE.—The Secretary, acting
14 through the Service, Indian tribes and tribal organiza-
15 tions, shall provide, to the extent feasible and to the extent
16 that funding is available, for the implementation of pro-
17 grams including—

18 “(1) a comprehensive continuum of behavioral
19 health care that provides for—

20 “(A) community based prevention, inter-
21 vention, outpatient and behavioral health
22 aftercare;

23 “(B) detoxification (social and medical);

24 “(C) acute hospitalization;

- 1 “(D) intensive outpatient or day treat-
- 2 ment;
- 3 “(E) residential treatment;
- 4 “(F) transitional living for those needing a
- 5 temporary stable living environment that is sup-
- 6 portive of treatment or recovery goals;
- 7 “(G) emergency shelter;
- 8 “(H) intensive case management;
- 9 “(I) traditional health care practices; and
- 10 “(J) diagnostic services, including the utili-
- 11 zation of neurological assessment technology;
- 12 and
- 13 “(2) behavioral health services for particular
- 14 populations, including—
- 15 “(A) for persons from birth through age
- 16 17, child behavioral health services, that
- 17 include—
- 18 “(i) pre-school and school age fetal al-
- 19 cohol disorder services, including assess-
- 20 ment and behavioral intervention);
- 21 “(ii) mental health or substance abuse
- 22 services (emotional, organic, alcohol, drug,
- 23 inhalant and tobacco);
- 24 “(iii) services for co-occurring dis-
- 25 orders (multiple diagnosis);

1 “(iv) prevention services that are fo-
 2 cused on individuals ages 5 years through
 3 10 years (alcohol, drug, inhalant and to-
 4 bacco);

5 “(v) early intervention, treatment and
 6 aftercare services that are focused on indi-
 7 viduals ages 11 years through 17 years;

8 “(vi) healthy choices or life style serv-
 9 ices (related to STD’s, domestic violence,
 10 sexual abuse, suicide, teen pregnancy, obe-
 11 sity, and other risk or safety issues);

12 “(vii) co-morbidity services;

13 “(B) for persons ages 18 years through 55
 14 years, adult behavioral health services that
 15 include—

16 “(i) early intervention, treatment and
 17 aftercare services;

18 “(ii) mental health and substance
 19 abuse services (emotional, alcohol, drug,
 20 inhalant and tobacco);

21 “(iii) services for co-occurring dis-
 22 orders (dual diagnosis) and co-morbidity;

23 “(iv) healthy choices and life style
 24 services (related to parenting, partners, do-

1 mestic violence, sexual abuse, suicide, obe-
2 sity, and other risk related behavior);

3 “(v) female specific treatment services
4 for—

5 “(I) women at risk of giving
6 birth to a child with a fetal alcohol
7 disorder;

8 “(II) substance abuse requiring
9 gender specific services;

10 “(III) sexual assault and domes-
11 tic violence; and

12 “(IV) healthy choices and life
13 style (parenting, partners, obesity,
14 suicide and other related behavioral
15 risk); and

16 “(vi) male specific treatment services
17 for—

18 “(I) substance abuse requiring
19 gender specific services;

20 “(II) sexual assault and domestic
21 violence; and

22 “(III) healthy choices and life
23 style (parenting, partners, obesity,
24 suicide and other risk related behav-
25 ior);

1 “(C) family behavioral health services,
2 including—

3 “(i) early intervention, treatment and
4 aftercare for affected families;

5 “(ii) treatment for sexual assault and
6 domestic violence; and

7 “(iii) healthy choices and life style (re-
8 lated to parenting, partners, domestic vio-
9 lence and other abuse issues);

10 “(D) for persons age 56 years and older,
11 elder behavioral health services including—

12 “(i) early intervention, treatment and
13 aftercare services that include—

14 “(I) mental health and substance
15 abuse services (emotional, alcohol,
16 drug, inhalant and tobacco);

17 “(II) services for co-occurring
18 disorders (dual diagnosis) and co-mor-
19 bidity; and

20 “(III) healthy choices and life
21 style services (managing conditions re-
22 lated to aging);

23 “(ii) elder women specific services
24 that include—

1 “(I) treatment for substance
2 abuse requiring gender specific serv-
3 ices and

4 “(II) treatment for sexual as-
5 sult, domestic violence and neglect;

6 “(iii) elder men specific services that
7 include—

8 “(I) treatment for substance
9 abuse requiring gender specific serv-
10 ices; and

11 “(II) treatment for sexual as-
12 sult, domestic violence and neglect;
13 and

14 “(iv) services for dementia regardless
15 of cause.

16 “(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

17 “(1) IN GENERAL.—The governing body of any
18 Indian tribe or tribal organization or urban Indian
19 organization may, at its discretion, adopt a resolu-
20 tion for the establishment of a community behavioral
21 health plan providing for the identification and co-
22 ordination of available resources and programs to
23 identify, prevent, or treat alcohol and other sub-
24 stance abuse, mental illness or dysfunctional and
25 self-destructive behavior, including child abuse and

1 family violence, among its members or its service
2 population. Such plan should include behavioral
3 health services, social services, intensive outpatient
4 services, and continuing after care.

5 “(2) TECHNICAL ASSISTANCE.—In furtherance
6 of a plan established pursuant to paragraph (1) and
7 at the request of a tribe, the appropriate agency,
8 service unit, or other officials of the Bureau of In-
9 dian Affairs and the Service shall cooperate with,
10 and provide technical assistance to, the Indian tribe
11 or tribal organization in the development of a plan
12 under paragraph (1). Upon the establishment of
13 such a plan and at the request of the Indian tribe
14 or tribal organization, such officials shall cooperate
15 with the Indian tribe or tribal organization in the
16 implementation of such plan.

17 “(3) FUNDING.—The Secretary, acting through
18 the Service, may make funding available to Indian
19 tribes and tribal organizations adopting a resolution
20 pursuant to paragraph (1) to obtain technical assist-
21 ance for the development of a community behavioral
22 health plan and to provide administrative support in
23 the implementation of such plan.

24 “(e) COORDINATED PLANNING.—The Secretary, act-
25 ing through the Service, Indian tribes, tribal organiza-

1 tions, and urban Indian organizations shall coordinate be-
2 havioral health planning, to the extent feasible, with other
3 Federal and State agencies, to ensure that comprehensive
4 behavioral health services are available to Indians without
5 regard to their place of residence.

6 “(f) FACILITIES ASSESSMENT.—Not later than 1
7 year after the date of enactment of this Act, the Secretary,
8 acting through the Service, shall make an assessment of
9 the need for inpatient mental health care among Indians
10 and the availability and cost of inpatient mental health
11 facilities which can meet such need. In making such as-
12 sessment, the Secretary shall consider the possible conver-
13 sion of existing, under-utilized service hospital beds into
14 psychiatric units to meet such need.

15 **“SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DE-**
16 **PARTMENT OF THE INTERIOR.**

17 “(a) IN GENERAL.—Not later than 1 year after the
18 date of enactment of this Act, the Secretary and the Sec-
19 retary of the Interior shall develop and enter into a memo-
20 randum of agreement, or review and update any existing
21 memoranda of agreement as required under section 4205
22 of the Indian Alcohol and Substance Abuse Prevention
23 and Treatment Act of 1986 (25 U.S.C. 2411), and under
24 which the Secretaries address—

1 “(1) the scope and nature of mental illness and
2 dysfunctional and self-destructive behavior, including
3 child abuse and family violence, among Indians;

4 “(2) the existing Federal, tribal, State, local,
5 and private services, resources, and programs avail-
6 able to provide mental health services for Indians;

7 “(3) the unmet need for additional services, re-
8 sources, and programs necessary to meet the needs
9 identified pursuant to paragraph (1);

10 “(4)(A) the right of Indians, as citizens of the
11 United States and of the States in which they re-
12 side, to have access to mental health services to
13 which all citizens have access;

14 “(B) the right of Indians to participate in, and
15 receive the benefit of, such services; and

16 “(C) the actions necessary to protect the exer-
17 cise of such right;

18 “(5) the responsibilities of the Bureau of Indian
19 Affairs and the Service, including mental health
20 identification, prevention, education, referral, and
21 treatment services (including services through multi-
22 disciplinary resource teams), at the central, area,
23 and agency and service unit levels to address the
24 problems identified in paragraph (1);

1 “(6) a strategy for the comprehensive coordina-
2 tion of the mental health services provided by the
3 Bureau of Indian Affairs and the Service to meet
4 the needs identified pursuant to paragraph (1),
5 including—

6 “(A) the coordination of alcohol and sub-
7 stance abuse programs of the Service, the Bu-
8 reau of Indian Affairs, and the various Indian
9 tribes (developed under the Indian Alcohol and
10 Substance Abuse Prevention and Treatment
11 Act of 1986) with the mental health initiatives
12 pursuant to this Act, particularly with respect
13 to the referral and treatment of dually-diag-
14 nosed individuals requiring mental health and
15 substance abuse treatment; and

16 “(B) ensuring that Bureau of Indian Af-
17 fairs and Service programs and services (includ-
18 ing multidisciplinary resource teams) address-
19 ing child abuse and family violence are coordi-
20 nated with such non-Federal programs and
21 services;

22 “(7) direct appropriate officials of the Bureau
23 of Indian Affairs and the Service, particularly at the
24 agency and service unit levels, to cooperate fully
25 with tribal requests made pursuant to community

1 behavioral health plans adopted under section 701(c)
2 and section 4206 of the Indian Alcohol and Sub-
3 stance Abuse Prevention and Treatment Act of 1986
4 (25 U.S.C. 2412); and

5 “(8) provide for an annual review of such
6 agreement by the 2 Secretaries and a report which
7 shall be submitted to Congress and made available
8 to the Indian tribes.

9 “(b) SPECIFIC PROVISIONS.—The memorandum of
10 agreement updated or entered into pursuant to subsection
11 (a) shall include specific provisions pursuant to which the
12 Service shall assume responsibility for—

13 “(1) the determination of the scope of the prob-
14 lem of alcohol and substance abuse among Indian
15 people, including the number of Indians within the
16 jurisdiction of the Service who are directly or indi-
17 rectly affected by alcohol and substance abuse and
18 the financial and human cost;

19 “(2) an assessment of the existing and needed
20 resources necessary for the prevention of alcohol and
21 substance abuse and the treatment of Indians af-
22 fected by alcohol and substance abuse; and

23 “(3) an estimate of the funding necessary to
24 adequately support a program of prevention of alco-

1 hol and substance abuse and treatment of Indians
2 affected by alcohol and substance abuse.

3 “(c) CONSULTATION.—The Secretary and the Sec-
4 retary of the Interior shall, in developing the memoran-
5 dum of agreement under subsection (a), consult with and
6 solicit the comments of—

7 “(1) Indian tribes and tribal organizations;

8 “(2) Indian individuals;

9 “(3) urban Indian organizations and other In-
10 dian organizations;

11 “(4) behavioral health service providers.

12 “(d) PUBLICATION.—The memorandum of agree-
13 ment under subsection (a) shall be published in the Fed-
14 eral Register. At the same time as the publication of such
15 agreement in the Federal Register, the Secretary shall
16 provide a copy of such memorandum to each Indian tribe,
17 tribal organization, and urban Indian organization.

18 **“SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PRE-**
19 **VENTION AND TREATMENT PROGRAM.**

20 “(a) ESTABLISHMENT.—

21 “(1) IN GENERAL.—The Secretary, acting
22 through the Service, Indian tribes and tribal organi-
23 zations consistent with section 701, shall provide a
24 program of comprehensive behavioral health preven-
25 tion and treatment and aftercare, including systems

1 of care and traditional health care practices, which
2 shall include—

3 “(A) prevention, through educational inter-
4 vention, in Indian communities;

5 “(B) acute detoxification or psychiatric
6 hospitalization and treatment (residential and
7 intensive outpatient);

8 “(C) community-based rehabilitation and
9 aftercare;

10 “(D) community education and involve-
11 ment, including extensive training of health
12 care, educational, and community-based person-
13 nel;

14 “(E) specialized residential treatment pro-
15 grams for high risk populations including preg-
16 nant and post partum women and their chil-
17 dren;

18 “(F) diagnostic services utilizing, when ap-
19 propriate, neuropsychiatric assessments which
20 include the use of the most advances technology
21 available; and

22 “(G) a telepsychiatry program that uses
23 experts in the field of pediatric psychiatry, and
24 that incorporates assessment, diagnosis and

1 treatment for children, including those children
2 with concurrent neurological disorders.

3 “(2) TARGET POPULATIONS.—The target popu-
4 lation of the program under paragraph (1) shall be
5 members of Indian tribes. Efforts to train and edu-
6 cate key members of the Indian community shall
7 target employees of health, education, judicial, law
8 enforcement, legal, and social service programs.

9 “(b) CONTRACT HEALTH SERVICES.—

10 “(1) IN GENERAL.—The Secretary, acting
11 through the Service (with the consent of the Indian
12 tribe to be served), Indian tribes and tribal organiza-
13 tions, may enter into contracts with public or private
14 providers of behavioral health treatment services for
15 the purpose of carrying out the program required
16 under subsection (a).

17 “(2) PROVISION OF ASSISTANCE.—In carrying
18 out this subsection, the Secretary shall provide as-
19 sistance to Indian tribes and tribal organizations to
20 develop criteria for the certification of behavioral
21 health service providers and accreditation of service
22 facilities which meet minimum standards for such
23 services and facilities.

1 **“SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.**

2 “(a) IN GENERAL.—Under the authority of the Act
3 of November 2, 1921 (25 U.S.C. 13) (commonly known
4 as the Snyder Act), the Secretary shall establish and
5 maintain a Mental Health Technician program within the
6 Service which—

7 “(1) provides for the training of Indians as
8 mental health technicians; and

9 “(2) employs such technicians in the provision
10 of community-based mental health care that includes
11 identification, prevention, education, referral, and
12 treatment services.

13 “(b) TRAINING.—In carrying out subsection (a)(1),
14 the Secretary shall provide high standard paraprofessional
15 training in mental health care necessary to provide quality
16 care to the Indian communities to be served. Such training
17 shall be based upon a curriculum developed or approved
18 by the Secretary which combines education in the theory
19 of mental health care with supervised practical experience
20 in the provision of such care.

21 “(c) SUPERVISION AND EVALUATION.—The Sec-
22 retary shall supervise and evaluate the mental health tech-
23 nicians in the training program under this section.

24 “(d) TRADITIONAL CARE.—The Secretary shall en-
25 sure that the program established pursuant to this section
26 involves the utilization and promotion of the traditional

1 Indian health care and treatment practices of the Indian
2 tribes to be served.

3 **“SEC. 705. LICENSING REQUIREMENT FOR MENTAL**
4 **HEALTH CARE WORKERS.**

5 “Subject to section 220, any person employed as a
6 psychologist, social worker, or marriage and family thera-
7 pist for the purpose of providing mental health care serv-
8 ices to Indians in a clinical setting under the authority
9 of this Act or through a funding agreement pursuant to
10 the Indian Self-Determination and Education Assistance
11 Act shall—

12 “(1) in the case of a person employed as a psy-
13 chologist to provide health care services, be licensed
14 as a clinical or counseling psychologist, or working
15 under the direct supervision of a clinical or counsel-
16 ing psychologist;

17 “(2) in the case of a person employed as a so-
18 cial worker, be licensed as a social worker or work-
19 ing under the direct supervision of a licensed social
20 worker; or

21 “(3) in the case of a person employed as a mar-
22 riage and family therapist, be licensed as a marriage
23 and family therapist or working under the direct su-
24 pervision of a licensed marriage and family thera-
25 pist.

1 **“SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.**

2 “(a) FUNDING.—The Secretary, consistent with sec-
3 tion 701, shall make funding available to Indian tribes,
4 tribal organizations and urban Indian organization to de-
5 velop and implement a comprehensive behavioral health
6 program of prevention, intervention, treatment, and re-
7 lapse prevention services that specifically addresses the
8 spiritual, cultural, historical, social, and child care needs
9 of Indian women, regardless of age.

10 “(b) USE OF FUNDS.—Funding provided pursuant to
11 this section may be used to—

12 “(1) develop and provide community training,
13 education, and prevention programs for Indian
14 women relating to behavioral health issues, including
15 fetal alcohol disorders;

16 “(2) identify and provide psychological services,
17 counseling, advocacy, support, and relapse preven-
18 tion to Indian women and their families; and

19 “(3) develop prevention and intervention models
20 for Indian women which incorporate traditional
21 health care practices, cultural values, and commu-
22 nity and family involvement.

23 “(c) CRITERIA.—The Secretary, in consultation with
24 Indian tribes and tribal organizations, shall establish cri-
25 teria for the review and approval of applications and pro-
26 posals for funding under this section.

1 “(d) EARMARK OF CERTAIN FUNDS.—Twenty per-
2 cent of the amounts appropriated to carry out this section
3 shall be used to make grants to urban Indian organiza-
4 tions funded under title V.

5 **“SEC. 707. INDIAN YOUTH PROGRAM.**

6 “(a) DETOXIFICATION AND REHABILITATION.—The
7 Secretary shall, consistent with section 701, develop and
8 implement a program for acute detoxification and treat-
9 ment for Indian youth that includes behavioral health
10 services. The program shall include regional treatment
11 centers designed to include detoxification and rehabilita-
12 tion for both sexes on a referral basis and programs devel-
13 oped and implemented by Indian tribes or tribal organiza-
14 tions at the local level under the Indian Self-Determina-
15 tion and Education Assistance Act. Regional centers shall
16 be integrated with the intake and rehabilitation programs
17 based in the referring Indian community.

18 “(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT
19 CENTERS OR FACILITIES.—

20 “(1) ESTABLISHMENT.—

21 “(A) IN GENERAL.—The Secretary, acting
22 through the Service, Indian tribes, or tribal or-
23 ganizations, shall construct, renovate, or, as
24 necessary, purchase, and appropriately staff
25 and operate, at least 1 youth regional treatment

1 center or treatment network in each area under
2 the jurisdiction of an area office.

3 “(B) AREA OFFICE IN CALIFORNIA.—For
4 purposes of this subsection, the area office in
5 California shall be considered to be 2 area of-
6 fices, 1 office whose jurisdiction shall be consid-
7 ered to encompass the northern area of the
8 State of California, and 1 office whose jurisdic-
9 tion shall be considered to encompass the re-
10 mainder of the State of California for the pur-
11 pose of implementing California treatment net-
12 works.

13 “(2) FUNDING.—For the purpose of staffing
14 and operating centers or facilities under this sub-
15 section, funding shall be made available pursuant to
16 the Act of November 2, 1921 (25 U.S.C. 13) (com-
17 monly known as the Snyder Act).

18 “(3) LOCATION.—A youth treatment center
19 constructed or purchased under this subsection shall
20 be constructed or purchased at a location within the
21 area described in paragraph (1) that is agreed upon
22 (by appropriate tribal resolution) by a majority of
23 the tribes to be served by such center.

24 “(4) SPECIFIC PROVISION OF FUNDS.—

1 “(A) IN GENERAL.—Notwithstanding any
2 other provision of this title, the Secretary may,
3 from amounts authorized to be appropriated for
4 the purposes of carrying out this section, make
5 funds available to—

6 “(i) the Tanana Chiefs Conference,
7 Incorporated, for the purpose of leasing,
8 constructing, renovating, operating and
9 maintaining a residential youth treatment
10 facility in Fairbanks, Alaska;

11 “(ii) the Southeast Alaska Regional
12 Health Corporation to staff and operate a
13 residential youth treatment facility without
14 regard to the proviso set forth in section
15 4(l) of the Indian Self-Determination and
16 Education Assistance Act (25 U.S.C.
17 450b(l));

18 “(iii) the Southern Indian Health
19 Council, for the purpose of staffing, oper-
20 ating, and maintaining a residential youth
21 treatment facility in San Diego County,
22 California; and

23 “(iv) the Navajo Nation, for the staff-
24 ing, operation, and maintenance of the
25 Four Corners Regional Adolescent Treat-

1 ment Center, a residential youth treatment
2 facility in New Mexico.

3 “(B) PROVISION OF SERVICES TO ELIGI-
4 BLE YOUTH.—Until additional residential youth
5 treatment facilities are established in Alaska
6 pursuant to this section, the facilities specified
7 in subparagraph (A) shall make every effort to
8 provide services to all eligible Indian youth re-
9 siding in such State.

10 “(c) INTERMEDIATE ADOLESCENT BEHAVIORAL
11 HEALTH SERVICES.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Service, Indian tribes and tribal organi-
14 zations, may provide intermediate behavioral health
15 services, which may incorporate traditional health
16 care practices, to Indian children and adolescents,
17 including—

18 “(A) pre-treatment assistance;

19 “(B) inpatient, outpatient, and after-care
20 services;

21 “(C) emergency care;

22 “(D) suicide prevention and crisis interven-
23 tion; and

24 “(E) prevention and treatment of mental
25 illness, and dysfunctional and self-destructive

1 behavior, including child abuse and family vio-
2 lence.

3 “(2) USE OF FUNDS.—Funds provided under
4 this subsection may be used—

5 “(A) to construct or renovate an existing
6 health facility to provide intermediate behav-
7 ioral health services;

8 “(B) to hire behavioral health profes-
9 sionals;

10 “(C) to staff, operate, and maintain an in-
11 termediate mental health facility, group home,
12 sober housing, transitional housing or similar
13 facilities, or youth shelter where intermediate
14 behavioral health services are being provided;
15 and

16 “(D) to make renovations and hire appro-
17 priate staff to convert existing hospital beds
18 into adolescent psychiatric units; and

19 “(E) to provide intensive home- and com-
20 munity-based services, including collaborative
21 systems of care.

22 “(3) CRITERIA.—The Secretary shall, in con-
23 sultation with Indian tribes and tribal organizations,
24 establish criteria for the review and approval of ap-

1 plications or proposals for funding made available
2 pursuant to this subsection.

3 “(d) FEDERALLY OWNED STRUCTURES.—

4 “(1) IN GENERAL.—The Secretary, acting
5 through the Service, shall, in consultation with In-
6 dian tribes and tribal organizations—

7 “(A) identify and use, where appropriate,
8 federally owned structures suitable for local res-
9 idential or regional behavioral health treatment
10 for Indian youth; and

11 “(B) establish guidelines, in consultation
12 with Indian tribes and tribal organizations, for
13 determining the suitability of any such Feder-
14 ally owned structure to be used for local resi-
15 dential or regional behavioral health treatment
16 for Indian youth.

17 “(2) TERMS AND CONDITIONS FOR USE OF
18 STRUCTURE.—Any structure described in paragraph
19 (1) may be used under such terms and conditions as
20 may be agreed upon by the Secretary and the agency
21 having responsibility for the structure and any In-
22 dian tribe or tribal organization operating the pro-
23 gram.

24 “(e) REHABILITATION AND AFTERCARE SERVICES.—

1 “(1) IN GENERAL.—The Secretary, an Indian
2 tribe or tribal organization, in cooperation with the
3 Secretary of the Interior, shall develop and imple-
4 ment within each service unit, community-based re-
5 habilitation and follow-up services for Indian youth
6 who have significant behavioral health problems, and
7 require long-term treatment, community reintegra-
8 tion, and monitoring to support the Indian youth
9 after their return to their home community.

10 “(2) ADMINISTRATION.—Services under para-
11 graph (1) shall be administered within each service
12 unit or tribal program by trained staff within the
13 community who can assist the Indian youth in con-
14 tinuing development of self-image, positive problem-
15 solving skills, and nonalcohol or substance abusing
16 behaviors. Such staff may include alcohol and sub-
17 stance abuse counselors, mental health professionals,
18 and other health professionals and paraprofessionals,
19 including community health representatives.

20 “(f) INCLUSION OF FAMILY IN YOUTH TREATMENT
21 PROGRAM.—In providing the treatment and other services
22 to Indian youth authorized by this section, the Secretary,
23 an Indian tribe or tribal organization shall provide for the
24 inclusion of family members of such youth in the treat-
25 ment programs or other services as may be appropriate.

1 Not less than 10 percent of the funds appropriated for
2 the purposes of carrying out subsection (e) shall be used
3 for outpatient care of adult family members related to the
4 treatment of an Indian youth under that subsection.

5 “(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
6 acting through the Service, Indian tribes, tribal organiza-
7 tions and urban Indian organizations, shall provide, con-
8 sistent with section 701, programs and services to prevent
9 and treat the abuse of multiple forms of substances, in-
10 cluding alcohol, drugs, inhalants, and tobacco, among In-
11 dian youth residing in Indian communities, on Indian res-
12 ervations, and in urban areas and provide appropriate
13 mental health services to address the incidence of mental
14 illness among such youth.

15 **“SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL**
16 **HEALTH FACILITIES DESIGN, CONSTRUCTION**
17 **AND STAFFING ASSESSMENT.**

18 “(a) IN GENERAL.—Not later than 1 year after the
19 date of enactment of this section, the Secretary, acting
20 through the Service, Indian tribes and tribal organiza-
21 tions, shall provide, in each area of the Service, not less
22 than 1 inpatient mental health care facility, or the equiva-
23 lent, for Indians with behavioral health problems.

24 “(b) TREATMENT OF CALIFORNIA.—For purposes of
25 this section, California shall be considered to be 2 areas

1 of the Service, 1 area whose location shall be considered
2 to encompass the northern area of the State of California
3 and 1 area whose jurisdiction shall be considered to en-
4 compass the remainder of the State of California.

5 “(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—
6 The Secretary shall consider the possible conversion of ex-
7 isting, under-utilized Service hospital beds into psychiatric
8 units to meet needs under this section.

9 **“SEC. 709. TRAINING AND COMMUNITY EDUCATION.**

10 “(a) COMMUNITY EDUCATION.—

11 “(1) IN GENERAL.—The Secretary, in coopera-
12 tion with the Secretary of the Interior, shall develop
13 and implement, or provide funding to enable Indian
14 tribes and tribal organization to develop and imple-
15 ment, within each service unit or tribal program a
16 program of community education and involvement
17 which shall be designed to provide concise and timely
18 information to the community leadership of each
19 tribal community.

20 “(2) EDUCATION.—A program under paragraph
21 (1) shall include education concerning behavioral
22 health for political leaders, tribal judges, law en-
23 forcement personnel, members of tribal health and
24 education boards, and other critical members of each
25 tribal community.

1 “(3) TRAINING.—Community-based training
2 (oriented toward local capacity development) under a
3 program under paragraph (1) shall include tribal
4 community provider training (designed for adult
5 learners from the communities receiving services for
6 prevention, intervention, treatment and aftercare).

7 “(b) TRAINING.—The Secretary shall, either directly
8 or through Indian tribes or tribal organization, provide in-
9 struction in the area of behavioral health issues, including
10 instruction in crisis intervention and family relations in
11 the context of alcohol and substance abuse, child sexual
12 abuse, youth alcohol and substance abuse, and the causes
13 and effects of fetal alcohol disorders, to appropriate em-
14 ployees of the Bureau of Indian Affairs and the Service,
15 and to personnel in schools or programs operated under
16 any contract with the Bureau of Indian Affairs or the
17 Service, including supervisors of emergency shelters and
18 halfway houses described in section 4213 of the Indian
19 Alcohol and Substance Abuse Prevention and Treatment
20 Act of 1986 (25 U.S.C. 2433).

21 “(c) COMMUNITY-BASED TRAINING MODELS.—In
22 carrying out the education and training programs required
23 by this section, the Secretary, acting through the Service
24 and in consultation with Indian tribes, tribal organiza-
25 tions, Indian behavioral health experts, and Indian alcohol

1 and substance abuse prevention experts, shall develop and
2 provide community-based training models. Such models
3 shall address—

4 “(1) the elevated risk of alcohol and behavioral
5 health problems faced by children of alcoholics;

6 “(2) the cultural, spiritual, and
7 multigenerational aspects of behavioral health prob-
8 lem prevention and recovery; and

9 “(3) community-based and multidisciplinary
10 strategies for preventing and treating behavioral
11 health problems.

12 **“SEC. 710. BEHAVIORAL HEALTH PROGRAM.**

13 “(a) PROGRAMS FOR INNOVATIVE SERVICES.—The
14 Secretary, acting through the Service, Indian tribes or
15 tribal organizations, consistent with Section 701, may de-
16 velop, implement, and carry out programs to deliver inno-
17 vative community-based behavioral health services to Indi-
18 ans.

19 “(b) CRITERIA.—The Secretary may award funding
20 for a project under subsection (a) to an Indian tribe or
21 tribal organization and may consider the following criteria:

22 “(1) Whether the project will address signifi-
23 cant unmet behavioral health needs among Indians.

24 “(2) Whether the project will serve a significant
25 number of Indians.

1 “(3) Whether the project has the potential to
2 deliver services in an efficient and effective manner.

3 “(4) Whether the tribe or tribal organization
4 has the administrative and financial capability to ad-
5 minister the project.

6 “(5) Whether the project will deliver services in
7 a manner consistent with traditional health care.

8 “(6) Whether the project is coordinated with,
9 and avoids duplication of, existing services.

10 “(c) FUNDING AGREEMENTS.—For purposes of this
11 subsection, the Secretary shall, in evaluating applications
12 or proposals for funding for projects to be operated under
13 any funding agreement entered into with the Service
14 under the Indian Self-Determination Act and Education
15 Assistance Act, use the same criteria that the Secretary
16 uses in evaluating any other application or proposal for
17 such funding.

18 **“SEC. 711. FETAL ALCOHOL DISORDER FUNDING.**

19 “(a) ESTABLISHMENT OF PROGRAM.—

20 “(1) IN GENERAL.—The Secretary, consistent
21 with Section 701, acting through Indian tribes, trib-
22 al organizations, and urban Indian organizations,
23 shall establish and operate fetal alcohol disorders
24 programs as provided for in this section for the pur-

1 poses of meeting the health status objective specified
2 in section 3(b).

3 “(2) USE OF FUNDS.—Funding provided pursu-
4 ant to this section shall be used to—

5 “(A) develop and provide community and
6 in-school training, education, and prevention
7 programs relating to fetal alcohol disorders;

8 “(B) identify and provide behavioral health
9 treatment to high-risk women;

10 “(C) identify and provide appropriate edu-
11 cational and vocational support, counseling, ad-
12 vocacy, and information to fetal alcohol disorder
13 affected persons and their families or care-
14 takers;

15 “(D) develop and implement counseling
16 and support programs in schools for fetal alco-
17 hol disorder affected children;

18 “(E) develop prevention and intervention
19 models which incorporate traditional practition-
20 ers, cultural and spiritual values and commu-
21 nity involvement;

22 “(F) develop, print, and disseminate edu-
23 cation and prevention materials on fetal alcohol
24 disorders;

1 “(G) develop and implement, through the
2 tribal consultation process, culturally sensitive
3 assessment and diagnostic tools including
4 dysmorphology clinics and multidisciplinary
5 fetal alcohol disorder clinics for use in tribal
6 and urban Indian communities;

7 “(H) develop early childhood intervention
8 projects from birth on to mitigate the effects of
9 fetal alcohol disorders; and

10 “(I) develop and fund community-based
11 adult fetal alcohol disorder housing and support
12 services.

13 “(3) CRITERIA.—The Secretary shall establish
14 criteria for the review and approval of applications
15 for funding under this section.

16 “(b) PROVISION OF SERVICES.—The Secretary, act-
17 ing through the Service, Indian tribes, tribal organizations
18 and urban Indian organizations, shall—

19 “(1) develop and provide services for the pre-
20 vention, intervention, treatment, and aftercare for
21 those affected by fetal alcohol disorders in Indian
22 communities; and

23 “(2) provide supportive services, directly or
24 through an Indian tribe, tribal organization or urban
25 Indian organization, including services to meet the

1 special educational, vocational, school-to-work transi-
2 tion, and independent living needs of adolescent and
3 adult Indians with fetal alcohol disorders.

4 “(c) TASK FORCE.—

5 “(1) IN GENERAL.—The Secretary shall estab-
6 lish a task force to be known as the Fetal Alcohol
7 Disorders Task Force to advise the Secretary in car-
8 rying out subsection (b).

9 “(2) COMPOSITION.—The task force under
10 paragraph (1) shall be composed of representatives
11 from the National Institute on Drug Abuse, the Na-
12 tional Institute on Alcohol and Alcoholism, the Of-
13 fice of Substance Abuse Prevention, the National In-
14 stitute of Mental Health, the Service, the Office of
15 Minority Health of the Department of Health and
16 Human Services, the Administration for Native
17 Americans, the National Institute of Child Health &
18 Human Development, the Centers for Disease Con-
19 trol and Prevention, the Bureau of Indian Affairs,
20 Indian tribes, tribal organizations, urban Indian
21 communities, and Indian fetal alcohol disorders ex-
22 perts.

23 “(d) APPLIED RESEARCH.—The Secretary, acting
24 through the Substance Abuse and Mental Health Services
25 Administration, shall make funding available to Indian

1 tribes, tribal organizations and urban Indian organizations
 2 for applied research projects which propose to elevate the
 3 understanding of methods to prevent, intervene, treat, or
 4 provide rehabilitation and behavioral health aftercare for
 5 Indians and urban Indians affected by fetal alcohol dis-
 6 orders.

7 “(e) URBAN INDIAN ORGANIZATIONS.—The Sec-
 8 retary shall ensure that 10 percent of the amounts appro-
 9 priated to carry out this section shall be used to make
 10 grants to urban Indian organizations funded under title
 11 V.

12 **“SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREAT-**
 13 **MENT PROGRAMS.**

14 “(a) ESTABLISHMENT.—The Secretary and the Sec-
 15 retary of the Interior, acting through the Service, Indian
 16 tribes and tribal organizations, shall establish, consistent
 17 with section 701, in each service area, programs involving
 18 treatment for—

19 “(1) victims of child sexual abuse; and

20 “(2) perpetrators of child sexual abuse.

21 “(b) USE OF FUNDS.—Funds provided under this
 22 section shall be used to—

23 “(1) develop and provide community education
 24 and prevention programs related to child sexual
 25 abuse;

1 “(2) identify and provide behavioral health
2 treatment to children who are victims of sexual
3 abuse and to their families who are affected by sexual
4 abuse;

5 “(3) develop prevention and intervention models
6 which incorporate traditional health care practitioners,
7 cultural and spiritual values, and community involvement;
8

9 “(4) develop and implement, through the tribal
10 consultation process, culturally sensitive assessment
11 and diagnostic tools for use in tribal and urban Indian
12 communities.

13 “(5) identify and provide behavioral health
14 treatment to perpetrators of child sexual abuse with
15 efforts being made to begin offender and behavioral
16 health treatment while the perpetrator is incarcerated
17 or at the earliest possible date if the perpetrator
18 is not incarcerated, and to provide treatment
19 after release to the community until it is determined
20 that the perpetrator is not a threat to children.

21 **“SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Service and in consultation with appropriate Federal
24 agencies, shall provide funding to Indian tribes, tribal organizations
25 and urban Indian organizations or, enter into

1 contracts with, or make grants to appropriate institutions,
 2 for the conduct of research on the incidence and preva-
 3 lence of behavioral health problems among Indians served
 4 by the Service, Indian tribes or tribal organizations and
 5 among Indians in urban areas. Research priorities under
 6 this section shall include—

7 “(1) the inter-relationship and inter-dependence
 8 of behavioral health problems with alcoholism and
 9 other substance abuse, suicide, homicides, other in-
 10 juries, and the incidence of family violence; and

11 “(2) the development of models of prevention
 12 techniques.

13 “(b) SPECIAL EMPHASIS.—The effect of the inter-re-
 14 lationships and interdependencies referred to in subsection
 15 (a)(1) on children, and the development of prevention
 16 techniques under subsection (a)(2) applicable to children,
 17 shall be emphasized.

18 **“SEC. 714. DEFINITIONS.**

19 “In this title:

20 “(1) ASSESSMENT.—The term ‘assessment’
 21 means the systematic collection, analysis and dis-
 22 semination of information on health status, health
 23 needs and health problems.

24 “(2) ALCOHOL RELATED NEURODEVELOP-
 25 MENTAL DISORDERS.—The term ‘alcohol related

1 neurodevelopmental disorders’ or ‘ARND’ with re-
 2 spect to an individual means the individual has a
 3 history of maternal alcohol consumption during
 4 pregnancy, central nervous system involvement such
 5 as developmental delay, intellectual deficit, or
 6 neurologic abnormalities, that behaviorally, there
 7 may be problems with irritability, and failure to
 8 thrive as infants, and that as children become older
 9 there will likely be hyperactivity, attention deficit,
 10 language dysfunction and perceptual and judgment
 11 problems.

12 “(3) BEHAVIORAL HEALTH.—The term ‘behav-
 13 ioral health’ means the blending of substances (alco-
 14 hol, drugs, inhalants and tobacco) abuse and mental
 15 health prevention and treatment, for the purpose of
 16 providing comprehensive services. Such term in-
 17 cludes the joint development of substance abuse and
 18 mental health treatment planning and coordinated
 19 case management using a multidisciplinary ap-
 20 proach.

21 “(4) BEHAVIORAL HEALTH AFTERCARE.—

22 “(A) IN GENERAL.—The term ‘behavioral
 23 health aftercare’ includes those activities and
 24 resources used to support recovery following in-
 25 patient, residential, intensive substance abuse

1 or mental health outpatient or outpatient treat-
2 ment, to help prevent or treat relapse, including
3 the development of an aftercare plan.

4 “(B) AFTERCARE PLAN.—Prior to the
5 time at which an individual is discharged from
6 a level of care, such as outpatient treatment, an
7 aftercare plan shall have been developed for the
8 individual. Such plan may use such resources as
9 community base therapeutic group care, transi-
10 tional living, a 12-step sponsor, a local 12-step
11 or other related support group, or other com-
12 munity based providers (such as mental health
13 professionals, traditional health care practition-
14 ers, community health aides, community health
15 representatives, mental health technicians, or
16 ministers).

17 “(5) DUAL DIAGNOSIS.—The term ‘dual diag-
18 nosis’ means coexisting substance abuse and mental
19 illness conditions or diagnosis. In individual with a
20 dual diagnosis may be referred to as a mentally ill
21 chemical abuser.

22 “(6) FETAL ALCOHOL DISORDERS.—The term
23 ‘fetal alcohol disorders’ means fetal alcohol syn-
24 drome, partial fetal alcohol syndrome, or alcohol re-
25 lated neural developmental disorder.

1 “(7) FETAL ALCOHOL SYNDROME.—The term
2 ‘fetal alcohol syndrome’ or ‘FAS’ with respect to an
3 individual means a syndrome in which the individual
4 has a history of maternal alcohol consumption dur-
5 ing pregnancy, and with respect to which the follow-
6 ing criteria should be met:

7 “(A) Central nervous system involvement
8 such as developmental delay, intellectual deficit,
9 microencephaly, or neurologic abnormalities.

10 “(B) Craniofacial abnormalities with at
11 least 2 of the following: microphthalmia, short
12 palpebral fissures, poorly developed philtrum,
13 thin upper lip, flat nasal bridge, and short
14 upturned nose.

15 “(C) Prenatal or postnatal growth delay.

16 “(8) PARTIAL FAS.—The term ‘partial FAS’
17 with respect to an individual means a history of ma-
18 ternal alcohol consumption during pregnancy having
19 most of the criteria of FAS, though not meeting a
20 minimum of at least 2 of the following: micro-oph-
21 thalmia, short palpebral fissures, poorly developed
22 philtrum, thin upper lip, flat nasal bridge, short
23 upturned nose.

24 “(9) REHABILITATION.—The term ‘rehabilita-
25 tion’ means to restore the ability or capacity to en-

1 gage in usual and customary life activities through
2 education and therapy.

3 “(10) SUBSTANCE ABUSE.—The term ‘sub-
4 stance abuse’ includes inhalant abuse.

5 **“SEC. 715. AUTHORIZATION OF APPROPRIATIONS.**

6 “There is authorized to be appropriated such sums
7 as may be necessary for each fiscal year through fiscal
8 year 2015 to carry out this title.

9 **“TITLE VIII—MISCELLANEOUS**

10 **“SEC. 801. REPORTS.**

11 “The President shall, at the time the budget is sub-
12 mitted under section 1105 of title 31, United States Code,
13 for each fiscal year transmit to the Congress a report
14 containing—

15 “(1) a report on the progress made in meeting
16 the objectives of this Act, including a review of pro-
17 grams established or assisted pursuant to this Act
18 and an assessment and recommendations of addi-
19 tional programs or additional assistance necessary
20 to, at a minimum, provide health services to Indians,
21 and ensure a health status for Indians, which are at
22 a parity with the health services available to and the
23 health status of, the general population, including
24 specific comparisons of appropriations provided and
25 those required for such parity;

1 “(2) a report on whether, and to what extent,
2 new national health care programs, benefits, initia-
3 tives, or financing systems have had an impact on
4 the purposes of this Act and any steps that the Sec-
5 retary may have taken to consult with Indian tribes
6 to address such impact, including a report on pro-
7 posed changes in the allocation of funding pursuant
8 to section 808;

9 “(3) a report on the use of health services by
10 Indians—

11 “(A) on a national and area or other rel-
12 evant geographical basis;

13 “(B) by gender and age;

14 “(C) by source of payment and type of
15 service;

16 “(D) comparing such rates of use with
17 rates of use among comparable non-Indian pop-
18 ulations; and

19 “(E) on the services provided under fund-
20 ing agreements pursuant to the Indian Self-De-
21 termination and Education Assistance Act;

22 “(4) a report of contractors concerning health
23 care educational loan repayments under section 110;

1 “(5) a general audit report on the health care
2 educational loan repayment program as required
3 under section 110(n);

4 “(6) a separate statement that specifies the
5 amount of funds requested to carry out the provi-
6 sions of section 201;

7 “(7) a report on infectious diseases as required
8 under section 212;

9 “(8) a report on environmental and nuclear
10 health hazards as required under section 214;

11 “(9) a report on the status of all health care fa-
12 cilities needs as required under sections 301(c)(2)
13 and 301(d);

14 “(10) a report on safe water and sanitary waste
15 disposal facilities as required under section
16 302(h)(1);

17 “(11) a report on the expenditure of non-service
18 funds for renovation as required under sections
19 305(a)(2) and 305(a)(3);

20 “(12) a report identifying the backlog of main-
21 tenance and repair required at Service and tribal fa-
22 cilities as required under section 314(a);

23 “(13) a report providing an accounting of reim-
24 bursement funds made available to the Secretary

1 under titles XVIII and XIX of the Social Security
2 Act as required under section 403(a);

3 “(14) a report on services sharing of the Serv-
4 ice, the Department of Veteran’s Affairs, and other
5 Federal agency health programs as required under
6 section 412(c)(2);

7 “(15) a report on the evaluation and renewal of
8 urban Indian programs as required under section
9 505;

10 “(16) a report on the findings and conclusions
11 derived from the demonstration project as required
12 under section 512(a)(2);

13 “(17) a report on the evaluation of programs as
14 required under section 513; and

15 “(18) a report on alcohol and substance abuse
16 as required under section 701(f).

17 **“SEC. 802. REGULATIONS.**

18 “(a) INITIATION OF RULEMAKING PROCEDURES.—

19 “(1) IN GENERAL.—Not later than 90 days
20 after the date of enactment of this Act, the Sec-
21 retary shall initiate procedures under subchapter III
22 of chapter 5 of title 5, United States Code, to nego-
23 tiate and promulgate such regulations or amend-
24 ments thereto that are necessary to carry out this
25 Act.

1 “(2) PUBLICATION.—Proposed regulations to
2 implement this Act shall be published in the Federal
3 Register by the Secretary not later than 270 days
4 after the date of enactment of this Act and shall
5 have not less than a 120 day comment period.

6 “(3) EXPIRATION OF AUTHORITY.—The author-
7 ity to promulgate regulations under this Act shall
8 expire 18 months from the date of enactment of this
9 Act.

10 “(b) RULEMAKING COMMITTEE.—A negotiated rule-
11 making committee established pursuant to section 565 of
12 title 5, United States Code, to carry out this section shall
13 have as its members only representatives of the Federal
14 Government and representatives of Indian tribes, and trib-
15 al organizations, a majority of whom shall be nominated
16 by and be representatives of Indian tribes, tribal organiza-
17 tions, and urban Indian organizations from each service
18 area.

19 “(c) ADAPTION OF PROCEDURES.—The Secretary
20 shall adapt the negotiated rulemaking procedures to the
21 unique context of self-governance and the government-to-
22 government relationship between the United States and
23 Indian tribes.

1 “(d) FAILURE TO PROMULGATE REGULATIONS.—
2 The lack of promulgated regulations shall not limit the
3 effect of this Act.

4 “(e) SUPREMACY OF PROVISIONS.—The provisions of
5 this Act shall supersede any conflicting provisions of law
6 (including any conflicting regulations) in effect on the day
7 before the date of enactment of the Indian Self-Deter-
8 mination Contract Reform Act of 1994, and the Secretary
9 is authorized to repeal any regulation that is inconsistent
10 with the provisions of this Act.

11 **“SEC. 803. PLAN OF IMPLEMENTATION.**

12 “Not later than 240 days after the date of enactment
13 of this Act, the Secretary, in consultation with Indian
14 tribes, tribal organizations, and urban Indian organiza-
15 tions, shall prepare and submit to Congress a plan that
16 shall explain the manner and schedule (including a sched-
17 ule of appropriate requests), by title and section, by which
18 the Secretary will implement the provisions of this Act.

19 **“SEC. 804. AVAILABILITY OF FUNDS.**

20 “Amounts appropriated under this Act shall remain
21 available until expended.

22 **“SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED**
23 **TO THE INDIAN HEALTH SERVICE.**

24 “Any limitation on the use of funds contained in an
25 Act providing appropriations for the Department for a pe-

1 riod with respect to the performance of abortions shall
 2 apply for that period with respect to the performance of
 3 abortions using funds contained in an Act providing ap-
 4 propriations for the Service.

5 **“SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.**

6 “(a) ELIGIBILITY.—

7 “(1) IN GENERAL.—Until such time as any
 8 subsequent law may otherwise provide, the following
 9 California Indians shall be eligible for health services
 10 provided by the Service:

11 “(A) Any member of a federally recognized
 12 Indian tribe.

13 “(B) Any descendant of an Indian who
 14 was residing in California on June 1, 1852, but
 15 only if such descendant—

16 “(i) is a member of the Indian com-
 17 munity served by a local program of the
 18 Service; and

19 “(ii) is regarded as an Indian by the
 20 community in which such descendant lives.

21 “(C) Any Indian who holds trust interests
 22 in public domain, national forest, or Indian res-
 23 ervation allotments in California.

24 “(D) Any Indian in California who is listed
 25 on the plans for distribution of the assets of

1 California rancherias and reservations under
2 the Act of August 18, 1958 (72 Stat. 619), and
3 any descendant of such an Indian.

4 “(b) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion may be construed as expanding the eligibility of Cali-
6 fornia Indians for health services provided by the Service
7 beyond the scope of eligibility for such health services that
8 applied on May 1, 1986.

9 **“SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

10 “(a) INELIGIBLE PERSONS.—

11 “(1) IN GENERAL.—Any individual who—

12 “(A) has not attained 19 years of age;

13 “(B) is the natural or adopted child, step-
14 child, foster-child, legal ward, or orphan of an
15 eligible Indian; and

16 “(C) is not otherwise eligible for the health
17 services provided by the Service,

18 shall be eligible for all health services provided by
19 the Service on the same basis and subject to the
20 same rules that apply to eligible Indians until such
21 individual attains 19 years of age. The existing and
22 potential health needs of all such individuals shall be
23 taken into consideration by the Service in determin-
24 ing the need for, or the allocation of, the health re-
25 sources of the Service. If such an individual has

1 been determined to be legally incompetent prior to
2 attaining 19 years of age, such individual shall re-
3 main eligible for such services until one year after
4 the date such disability has been removed.

5 “(2) SPOUSES.—Any spouse of an eligible In-
6 dian who is not an Indian, or who is of Indian de-
7 scend but not otherwise eligible for the health serv-
8 ices provided by the Service, shall be eligible for
9 such health services if all of such spouses or spouses
10 who are married to members of the Indian tribe
11 being served are made eligible, as a class, by an ap-
12 propriate resolution of the governing body of the In-
13 dian tribe or tribal organization providing such serv-
14 ices. The health needs of persons made eligible
15 under this paragraph shall not be taken into consid-
16 eration by the Service in determining the need for,
17 or allocation of, its health resources.

18 “(b) PROGRAMS AND SERVICES.—

19 “(1) PROGRAMS.—

20 “(A) IN GENERAL.—The Secretary may
21 provide health services under this subsection
22 through health programs operated directly by
23 the Service to individuals who reside within the
24 service area of a service unit and who are not
25 eligible for such health services under any other

1 subsection of this section or under any other
2 provision of law if—

3 “(i) the Indian tribe (or, in the case
4 of a multi-tribal service area, all the Indian
5 tribes) served by such service unit requests
6 such provision of health services to such
7 individuals; and

8 “(ii) the Secretary and the Indian
9 tribe or tribes have jointly determined
10 that—

11 “(I) the provision of such health
12 services will not result in a denial or
13 diminution of health services to eligi-
14 ble Indians; and

15 “(II) there is no reasonable alter-
16 native health program or services,
17 within or without the service area of
18 such service unit, available to meet
19 the health needs of such individuals.

20 “(B) FUNDING AGREEMENTS.—In the case
21 of health programs operated under a funding
22 agreement entered into under the Indian Self-
23 Determination and Educational Assistance Act,
24 the governing body of the Indian tribe or tribal
25 organization providing health services under

1 such funding agreement is authorized to deter-
2 mine whether health services should be provided
3 under such funding agreement to individuals
4 who are not eligible for such health services
5 under any other subsection of this section or
6 under any other provision of law. In making
7 such determinations, the governing body of the
8 Indian tribe or tribal organization shall take
9 into account the considerations described in
10 subparagraph (A)(ii).

11 “(2) LIABILITY FOR PAYMENT.—

12 “(A) IN GENERAL.—Persons receiving
13 health services provided by the Service by rea-
14 son of this subsection shall be liable for pay-
15 ment of such health services under a schedule
16 of charges prescribed by the Secretary which, in
17 the judgment of the Secretary, results in reim-
18 bursement in an amount not less than the ac-
19 tual cost of providing the health services. Not-
20 withstanding section 1880 of the Social Secu-
21 rity Act, section 402(a) of this Act, or any
22 other provision of law, amounts collected under
23 this subsection, including medicare or medicaid
24 reimbursements under titles XVIII and XIX of
25 the Social Security Act, shall be credited to the

1 account of the program providing the service
2 and shall be used solely for the provision of
3 health services within that program. Amounts
4 collected under this subsection shall be available
5 for expenditure within such program for not to
6 exceed 1 fiscal year after the fiscal year in
7 which collected.

8 “(B) SERVICES FOR INDIGENT PERSONS.—
9 Health services may be provided by the Sec-
10 retary through the Service under this sub-
11 section to an indigent person who would not be
12 eligible for such health services but for the pro-
13 visions of paragraph (1) only if an agreement
14 has been entered into with a State or local gov-
15 ernment under which the State or local govern-
16 ment agrees to reimburse the Service for the
17 expenses incurred by the Service in providing
18 such health services to such indigent person.

19 “(3) SERVICE AREAS.—

20 “(A) SERVICE TO ONLY ONE TRIBE.—In
21 the case of a service area which serves only one
22 Indian tribe, the authority of the Secretary to
23 provide health services under paragraph (1)(A)
24 shall terminate at the end of the fiscal year suc-
25 ceeding the fiscal year in which the governing

1 body of the Indian tribe revokes its concurrence
2 to the provision of such health services.

3 “(B) MULTI-TRIBAL AREAS.—In the case
4 of a multi-tribal service area, the authority of
5 the Secretary to provide health services under
6 paragraph (1)(A) shall terminate at the end of
7 the fiscal year succeeding the fiscal year in
8 which at least 51 percent of the number of In-
9 dian tribes in the service area revoke their con-
10 currence to the provision of such health serv-
11 ices.

12 “(c) PURPOSE FOR PROVIDING SERVICES.—The
13 Service may provide health services under this subsection
14 to individuals who are not eligible for health services pro-
15 vided by the Service under any other subsection of this
16 section or under any other provision of law in order to—

17 “(1) achieve stability in a medical emergency;

18 “(2) prevent the spread of a communicable dis-
19 ease or otherwise deal with a public health hazard;

20 “(3) provide care to non-Indian women preg-
21 nant with an eligible Indian’s child for the duration
22 of the pregnancy through post partum; or

23 “(4) provide care to immediate family members
24 of an eligible person if such care is directly related
25 to the treatment of the eligible person.

1 “(d) HOSPITAL PRIVILEGES.—Hospital privileges in
2 health facilities operated and maintained by the Service
3 or operated under a contract entered into under the Indian
4 Self-Determination Education Assistance Act may be ex-
5 tended to non-Service health care practitioners who pro-
6 vide services to persons described in subsection (a) or (b).
7 Such non-Service health care practitioners may be re-
8 garded as employees of the Federal Government for pur-
9 poses of section 1346(b) and chapter 171 of title 28,
10 United States Code (relating to Federal tort claims) only
11 with respect to acts or omissions which occur in the course
12 of providing services to eligible persons as a part of the
13 conditions under which such hospital privileges are ex-
14 tended.

15 “(e) DEFINITION.—In this section, the term ‘eligible
16 Indian’ means any Indian who is eligible for health serv-
17 ices provided by the Service without regard to the provi-
18 sions of this section.

19 **“SEC. 808. REALLOCATION OF BASE RESOURCES.**

20 “(a) REQUIREMENT OF REPORT.—Notwithstanding
21 any other provision of law, any allocation of Service funds
22 for a fiscal year that reduces by 5 percent or more from
23 the previous fiscal year the funding for any recurring pro-
24 gram, project, or activity of a service unit may be imple-
25 mented only after the Secretary has submitted to the

1 President, for inclusion in the report required to be trans-
2 mitted to the Congress under section 801, a report on the
3 proposed change in allocation of funding, including the
4 reasons for the change and its likely effects.

5 “(b) NONAPPLICATION OF SECTION.—Subsection (a)
6 shall not apply if the total amount appropriated to the
7 Service for a fiscal year is less than the amount appro-
8 priated to the Service for previous fiscal year.

9 **“SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.**

10 “The Secretary shall provide for the dissemination to
11 Indian tribes of the findings and results of demonstration
12 projects conducted under this Act.

13 **“SEC. 810. PROVISION OF SERVICES IN MONTANA.**

14 “(a) IN GENERAL.—The Secretary, acting through
15 the Service, shall provide services and benefits for Indians
16 in Montana in a manner consistent with the decision of
17 the United States Court of Appeals for the Ninth Circuit
18 in *McNabb for McNabb v. Bowen*, 829 F.2d 787 (9th Cr.
19 1987).

20 “(b) RULE OF CONSTRUCTION.—The provisions of
21 subsection (a) shall not be construed to be an expression
22 of the sense of the Congress on the application of the deci-
23 sion described in subsection (a) with respect to the provi-
24 sion of services or benefits for Indians living in any State
25 other than Montana.

1 **“SEC. 811. MORATORIUM.**

2 “During the period of the moratorium imposed by
3 Public Law 100–446 on implementation of the final rule
4 published in the Federal Register on September 16, 1987,
5 by the Health Resources and Services Administration, re-
6 lating to eligibility for the health care services of the Serv-
7 ice, the Service shall provide services pursuant to the cri-
8 teria for eligibility for such services that were in effect
9 on September 15, 1987, subject to the provisions of sec-
10 tions 806 and 807 until such time as new criteria govern-
11 ing eligibility for services are developed in accordance with
12 section 802.

13 **“SEC. 812. TRIBAL EMPLOYMENT.**

14 “For purposes of section 2(2) of the Act of July 5,
15 1935 (49 Stat. 450, Chapter 372), an Indian tribe or trib-
16 al organization carrying out a funding agreement under
17 the Self-Determination and Education Assistance Act
18 shall not be considered an employer.

19 **“SEC. 813. PRIME VENDOR.**

20 “For purposes of section 4 of Public Law 102–585
21 (38 U.S.C. 812) Indian tribes and tribal organizations
22 carrying out a grant, cooperative agreement, or funding
23 agreement under the Indian Self-Determination and Edu-
24 cation Assistance Act (25 U.S.C. 450 et seq.) shall be
25 deemed to be an executive agency and part of the Service
26 and, as such, may act as an ordering agent of the Service

1 and the employees of the tribe or tribal organization may
2 order supplies on behalf thereof on the same basis as em-
3 ployees of the Service.

4 **“SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN**
5 **HEALTH CARE ENTITLEMENT.**

6 “(a) ESTABLISHMENT.—There is hereby established
7 the National Bi-Partisan Indian Health Care Entitlement
8 Commission (referred to in this Act as the ‘Commission’).

9 “(b) MEMBERSHIP.—The Commission shall be com-
10 posed of 25 members, to be appointed as follows:

11 “(1) Ten members of Congress, of which—

12 “(A) three members shall be from the
13 House of Representatives and shall be ap-
14 pointed by the majority leader;

15 “(B) three members shall be from the
16 House of Representatives and shall be ap-
17 pointed by the minority leader;

18 “(C) two members shall be from the Sen-
19 ate and shall be appointed by the majority lead-
20 er; and

21 “(D) two members shall be from the Sen-
22 ate and shall be appointed by the minority lead-
23 er;

24 who shall each be members of the committees of
25 Congress that consider legislation affecting the pro-

1 vision of health care to Indians and who shall elect
2 the chairperson and vice-chairperson of the Commis-
3 sion.

4 “(2) Twelve individuals to be appointed by the
5 members of the Commission appointed under para-
6 graph (1), of which at least 1 shall be from each
7 service area as currently designated by the Director
8 of the Service, to be chosen from among 3 nominees
9 from each such area as selected by the Indian tribes
10 within the area, with due regard being given to the
11 experience and expertise of the nominees in the pro-
12 vision of health care to Indians and with due regard
13 being given to a reasonable representation on the
14 Commission of members who are familiar with var-
15 ious health care delivery modes and who represent
16 tribes of various size populations.

17 “(3) Three individuals shall be appointed by the
18 Director of the Service from among individual who
19 are knowledgeable about the provision of health care
20 to Indians, at least 1 of whom shall be appointed
21 from among 3 nominees from each program that is
22 funded in whole or in part by the Service primarily
23 or exclusively for the benefit of urban Indians.

24 All those persons appointed under paragraphs (2) and (3)
25 shall be members of Federally recognized Indian tribes.

1 “(c) TERMS.—

2 “(1) IN GENERAL.—Members of the Commis-
3 sion shall serve for the life of the Commission.

4 “(2) APPOINTMENT OF MEMBERS.—Members of
5 the Commission shall be appointed under subsection
6 (b)(1) not later than 90 days after the date of enact-
7 ment of this Act, and the remaining members of the
8 Commission shall be appointed not later than 60
9 days after the date on which the members are ap-
10 pointed under such subsection.

11 “(3) VACANCY.—A vacancy in the membership
12 of the Commission shall be filled in the manner in
13 which the original appointment was made.

14 “(d) DUTIES OF THE COMMISSION.—The Commis-
15 sion shall carry out the following duties and functions:

16 “(1) Review and analyze the recommendations
17 of the report of the study committee established
18 under paragraph (3) to the Commission.

19 “(2) Make recommendations to Congress for
20 providing health services for Indian persons as an
21 entitlement, giving due regard to the effects of such
22 a programs on existing health care delivery systems
23 for Indian persons and the effect of such programs
24 on the sovereign status of Indian tribes;

1 “(3) Establish a study committee to be com-
2 posed of those members of the Commission ap-
3 pointed by the Director of the Service and at least
4 4 additional members of Congress from among the
5 members of the Commission which shall—

6 “(A) to the extent necessary to carry out
7 its duties, collect and compile data necessary to
8 understand the extent of Indian needs with re-
9 gard to the provision of health services, regard-
10 less of the location of Indians, including holding
11 hearings and soliciting the views of Indians, In-
12 dian tribes, tribal organizations and urban In-
13 dian organizations, and which may include au-
14 thorizing and funding feasibility studies of var-
15 ious models for providing and funding health
16 services for all Indian beneficiaries including
17 those who live outside of a reservation, tempo-
18 rarily or permanently;

19 “(B) make recommendations to the Com-
20 mission for legislation that will provide for the
21 delivery of health services for Indians as an en-
22 titlement, which shall, at a minimum, address
23 issues of eligibility, benefits to be provided, in-
24 cluding recommendations regarding from whom
25 such health services are to be provided, and the

1 cost, including mechanisms for funding of the
2 health services to be provided;

3 “(C) determine the effect of the enactment
4 of such recommendations on the existing system
5 of the delivery of health services for Indians;

6 “(D) determine the effect of a health serv-
7 ices entitlement program for Indian persons on
8 the sovereign status of Indian tribes;

9 “(E) not later than 12 months after the
10 appointment of all members of the Commission,
11 make a written report of its findings and rec-
12 ommendations to the Commission, which report
13 shall include a statement of the minority and
14 majority position of the committee and which
15 shall be disseminated, at a minimum, to each
16 federally recognized Indian tribe, tribal organi-
17 zation and urban Indian organization for com-
18 ment to the Commission; and

19 “(F) report regularly to the full Commis-
20 sion regarding the findings and recommenda-
21 tions developed by the committee in the course
22 of carrying out its duties under this section.

23 “(4) Not later than 18 months after the date
24 of appointment of all members of the Commission,
25 submit a written report to Congress containing a

1 recommendation of policies and legislation to imple-
2 ment a policy that would establish a health care sys-
3 tem for Indians based on the delivery of health serv-
4 ices as an entitlement, together with a determination
5 of the implications of such an entitlement system on
6 existing health care delivery systems for Indians and
7 on the sovereign status of Indian tribes.

8 “(e) ADMINISTRATIVE PROVISIONS.—

9 “(1) COMPENSATION AND EXPENSES.—

10 “(A) CONGRESSIONAL MEMBERS.—Each
11 member of the Commission appointed under
12 subsection (b)(1) shall receive no additional
13 pay, allowances, or benefits by reason of their
14 service on the Commission and shall receive
15 travel expenses and per diem in lieu of subsist-
16 ence in accordance with sections 5702 and 5703
17 of title 5, United States Code.

18 “(B) OTHER MEMBERS.—The members of
19 the Commission appointed under paragraphs
20 (2) and (3) of subsection (b), while serving on
21 the business of the Commission (including trav-
22 el time) shall be entitled to receive compensa-
23 tion at the per diem equivalent of the rate pro-
24 vided for level IV of the Executive Schedule
25 under section 5315 of title 5, United States

1 Code, and while so serving away from home and
2 the member's regular place of business, be al-
3 lowed travel expenses, as authorized by the
4 chairperson of the Commission. For purposes of
5 pay (other than pay of members of the Commis-
6 sion) and employment benefits, rights, and
7 privileges, all personnel of the Commission shall
8 be treated as if they were employees of the
9 United States Senate.

10 “(2) MEETINGS AND QUORUM.—

11 “(A) MEETINGS.—The Commission shall
12 meet at the call of the chairperson.

13 “(B) QUORUM.—A quorum of the Commis-
14 sion shall consist of not less than 15 members,
15 of which not less than 6 of such members shall
16 be appointees under subsection (b)(1) and not
17 less than 9 of such members shall be Indians.

18 “(3) DIRECTOR AND STAFF.—

19 “(A) EXECUTIVE DIRECTOR.—The mem-
20 bers of the Commission shall appoint an execu-
21 tive director of the Commission. The executive
22 director shall be paid the rate of basic pay
23 equal to that for level V of the Executive Sched-
24 ule.

1 “(B) STAFF.—With the approval of the
2 Commission, the executive director may appoint
3 such personnel as the executive director deems
4 appropriate.

5 “(C) APPLICABILITY OF CIVIL SERVICE
6 LAWS.—The staff of the Commission shall be
7 appointed without regard to the provisions of
8 title 5, United States Code, governing appoint-
9 ments in the competitive service, and shall be
10 paid without regard to the provisions of chapter
11 51 and subchapter III of chapter 53 of such
12 title (relating to classification and General
13 Schedule pay rates).

14 “(D) EXPERTS AND CONSULTANTS.—With
15 the approval of the Commission, the executive
16 director may procure temporary and intermit-
17 tent services under section 3109(b) of title 5,
18 United States Code.

19 “(E) FACILITIES.—The Administrator of
20 the General Services Administration shall locate
21 suitable office space for the operation of the
22 Commission. The facilities shall serve as the
23 headquarters of the Commission and shall in-
24 clude all necessary equipment and incidentals

1 required for the proper functioning of the Com-
2 mission.

3 “(f) POWERS.—

4 “(1) HEARINGS AND OTHER ACTIVITIES.—For
5 the purpose of carrying out its duties, the Commis-
6 sion may hold such hearings and undertake such
7 other activities as the Commission determines to be
8 necessary to carry out its duties, except that at least
9 6 regional hearings shall be held in different areas
10 of the United States in which large numbers of Indi-
11 ans are present. Such hearings shall be held to so-
12 licit the views of Indians regarding the delivery of
13 health care services to them. To constitute a hearing
14 under this paragraph, at least 5 members of the
15 Commission, including at least 1 member of Con-
16 gress, must be present. Hearings held by the study
17 committee established under this section may be
18 counted towards the number of regional hearings re-
19 quired by this paragraph.

20 “(2) STUDIES BY GAO.—Upon request of the
21 Commission, the Comptroller General shall conduct
22 such studies or investigations as the Commission de-
23 termines to be necessary to carry out its duties.

24 “(3) COST ESTIMATES.—

1 “(A) IN GENERAL.—The Director of the
2 Congressional Budget Office or the Chief Actu-
3 ary of the Health Care Financing Administra-
4 tion, or both, shall provide to the Commission,
5 upon the request of the Commission, such cost
6 estimates as the Commission determines to be
7 necessary to carry out its duties.

8 “(B) REIMBURSEMENTS.—The Commis-
9 sion shall reimburse the Director of the Con-
10 gressional Budget Office for expenses relating
11 to the employment in the office of the Director
12 of such additional staff as may be necessary for
13 the Director to comply with requests by the
14 Commission under subparagraph (A).

15 “(4) DETAIL OF FEDERAL EMPLOYEES.—Upon
16 the request of the Commission, the head of any Fed-
17 eral Agency is authorized to detail, without reim-
18 bursement, any of the personnel of such agency to
19 the Commission to assist the Commission in carry-
20 ing out its duties. Any such detail shall not interrupt
21 or otherwise affect the civil service status or privi-
22 leges of the Federal employee.

23 “(5) TECHNICAL ASSISTANCE.—Upon the re-
24 quest of the Commission, the head of a Federal
25 Agency shall provide such technical assistance to the

1 Commission as the Commission determines to be
2 necessary to carry out its duties.

3 “(6) USE OF MAILS.—The Commission may use
4 the United States mails in the same manner and
5 under the same conditions as Federal Agencies and
6 shall, for purposes of the frank, be considered a
7 commission of Congress as described in section 3215
8 of title 39, United States Code.

9 “(7) OBTAINING INFORMATION.—The Commis-
10 sion may secure directly from the any Federal Agen-
11 cy information necessary to enable it to carry out its
12 duties, if the information may be disclosed under
13 section 552 of title 4, United States Code. Upon re-
14 quest of the chairperson of the Commission, the
15 head of such agency shall furnish such information
16 to the Commission.

17 “(8) SUPPORT SERVICES.—Upon the request of
18 the Commission, the Administrator of General Serv-
19 ices shall provide to the Commission on a reimburs-
20 able basis such administrative support services as
21 the Commission may request.

22 “(9) PRINTING.—For purposes of costs relating
23 to printing and binding, including the cost of per-
24 sonnel detailed from the Government Printing Of-

1 fice, the Commission shall be deemed to be a com-
 2 mittee of the Congress.

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 4 is authorized to be appropriated \$4,000,000 to carry out
 5 this section. The amount appropriated under this sub-
 6 section shall not be deducted from or affect any other ap-
 7 propriation for health care for Indian persons.

8 **“SEC. 815. APPROPRIATIONS; AVAILABILITY.**

9 “Any new spending authority (described in subsection
 10 (c)(2)(A) or (B) of section 401 of the Congressional Budg-
 11 et Act of 1974) which is provided under this Act shall
 12 be effective for any fiscal year only to such extent or in
 13 such amounts as are provided in appropriation Acts.

14 **“SEC. 816. AUTHORIZATION OF APPROPRIATIONS.**

15 “There is authorized to be appropriated such sums
 16 as may be necessary for each fiscal year through fiscal
 17 year 2015 to carry out this title.”.

18 **TITLE II—CONFORMING AMEND-**
 19 **MENTS TO THE SOCIAL SECU-**
 20 **RITY ACT**

21 **Subtitle A—Medicare**

22 **SEC. 201. LIMITATIONS ON CHARGES.**

23 Section 1866(a)(1) of the Social Security Act (42
 24 U.S.C. 1395cc(a)(1)) is amended—

1 (1) in subparagraph (R), by striking “and” at
2 the end;

3 (2) in subparagraph (S), by striking the period
4 and inserting “, and”; and

5 (3) by adding at the end the following:

6 “(T) in the case of hospitals and critical access
7 hospitals which provide inpatient hospital services
8 for which payment may be made under this title, to
9 accept as payment in full for services that are cov-
10 ered under and furnished to an individual eligible for
11 the contract health services program operated by the
12 Indian Health Service, by an Indian tribe or tribal
13 organization, or furnished to an urban Indian eligi-
14 ble for health services purchased by an urban Indian
15 organization (as those terms are defined in section
16 4 of the Indian Health Care Improvement Act), in
17 accordance with such admission practices and such
18 payment methodology and amounts as are prescribed
19 under regulations issued by the Secretary.”.

20 **SEC. 202. QUALIFIED INDIAN HEALTH PROGRAM.**

21 Title XVIII of the Social Security Act (42 U.S.C.
22 1395 et seq.) is amended by inserting after section 1880
23 the following:

24 “QUALIFIED INDIAN HEALTH PROGRAM

25 “SEC. 1880A. (a) DEFINITION OF QUALIFIED IN-
26 DIAN HEALTH PROGRAM.—In this section:

1 “(1) IN GENERAL.—The term ‘qualified Indian
2 health program’ means a health program operated
3 by—

4 “(A) the Indian Health Service;

5 “(B) an Indian tribe or tribal organization
6 or an urban Indian organization (as those
7 terms are defined in section 4 of the Indian
8 Health Care Improvement Act) and which is
9 funded in whole or part by the Indian Health
10 Service under the Indian Self Determination
11 and Education Assistance Act; or

12 “(C) an urban Indian organization (as so
13 defined) and which is funded in whole or in
14 part under title V of the Indian Health Care
15 Improvement Act.

16 “(2) INCLUDED PROGRAMS AND ENTITIES.—
17 Such term may include 1 or more hospital, nursing
18 home, home health program, clinic, ambulance serv-
19 ice or other health program that provides a service
20 for which payments may be made under this title
21 and which is covered in the cost report submitted
22 under this title or title XIX for the qualified Indian
23 health program.

24 “(b) ELIGIBILITY FOR PAYMENTS.—A qualified In-
25 dian health program shall be eligible for payments under

1 this title, notwithstanding sections 1814(c) and 1835(d),
2 if and for so long as the program meets all the conditions
3 and requirements set forth in this section.

4 “(c) DETERMINATION OF PAYMENTS.—

5 “(1) IN GENERAL.—Notwithstanding any other
6 provision in the law, a qualified Indian health pro-
7 gram shall be entitled to receive payment based on
8 an all-inclusive rate which shall be calculated to pro-
9 vide full cost recovery for the cost of furnishing serv-
10 ices provided under this section.

11 “(2) DEFINITION OF FULL COST RECOVERY.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), in this section, the term ‘full cost re-
14 covery’ means the sum of—

15 “(i) the direct costs, which are reason-
16 able, adequate and related to the cost of
17 furnishing such services, taking into ac-
18 count the unique nature, location, and
19 service population of the qualified Indian
20 health program, and which shall include di-
21 rect program, administrative, and overhead
22 costs, without regard to the customary or
23 other charge or any fee schedule that
24 would otherwise be applicable; and

1 “(ii) indirect costs which, in the case
2 of a qualified Indian health program—

3 “(I) for which an indirect cost
4 rate (as that term is defined in sec-
5 tion 4(g) of the Indian Self-Deter-
6 mination and Education Assistance
7 Act) has been established, shall be not
8 less than an amount determined on
9 the basis of the indirect cost rate; or

10 “(II) for which no such rate has
11 been established, shall be not less
12 than the administrative costs specifi-
13 cally associated with the delivery of
14 the services being provided.

15 “(B) LIMITATION.—Notwithstanding any
16 other provision of law, the amount determined
17 to be payable as full cost recovery may not be
18 reduced for co-insurance, co-payments, or
19 deductibles when the service was provided to an
20 Indian entitled under Federal law to receive the
21 service from the Indian Health Service, an In-
22 dian tribe or tribal organization, or an urban
23 Indian organization or because of any limita-
24 tions on payment provided for in any managed
25 care plan.

1 “(3) OUTSTATIONING COSTS.—In addition to
2 full cost recovery, a qualified Indian health program
3 shall be entitled to reasonable outstationing costs,
4 which shall include all administrative costs associ-
5 ated with outreach and acceptance of eligibility ap-
6 plications for any Federal or State health program
7 including the programs established under this title,
8 title XIX, and XXI.

9 “(4) DETERMINATION OF ALL-INCLUSIVE EN-
10 COUNTER OR PER DIEM AMOUNT.—

11 “(A) IN GENERAL.—Costs identified for
12 services addressed in a cost report submitted by
13 a qualified Indian health program shall be used
14 to determine an all-inclusive encounter or per
15 diem payment amount for such services.

16 “(B) NO SINGLE REPORT REQUIRE-
17 MENT.—Not all qualified Indian health pro-
18 grams provided or administered by the Indian
19 Health Service, an Indian tribe or tribal organi-
20 zation, or an urban Indian organization need be
21 combined into a single cost report.

22 “(C) PAYMENT FOR ITEMS NOT COVERED
23 BY A COST REPORT.—A full cost recovery pay-
24 ment for services not covered by a cost report

1 shall be made on a fee-for-service, encounter, or
2 per diem basis.

3 “(5) OPTIONAL DETERMINATION.—The full
4 cost recovery rate provided for in paragraphs (1)
5 through (3) may be determined, at the election of
6 the qualified Indian health program, by the Health
7 Care Financing Administration or by the State
8 agency responsible for administering the State plan
9 under title XIX and shall be valid for reimburse-
10 ments made under this title, title XIX, and title
11 XXI. The costs described in paragraph (2)(A) shall
12 be calculated under whatever methodology yields the
13 greatest aggregate payment for the cost reporting
14 period, provided that such methodology shall be ad-
15 justed to include adjustments to such payment to
16 take into account for those qualified Indian health
17 programs that include hospitals—

18 “(A) a significant decrease in discharges;

19 “(B) costs for graduate medical education
20 programs;

21 “(C) additional payment as a disproport-
22 ionate share hospital with a payment adjust-
23 ment factor of 10; and

24 “(D) payment for outlier cases.

1 “(6) ELECTION OF PAYMENT.—A qualified In-
2 dian health program may elect to receive payment
3 for services provided under this section—

4 “(A) on the full cost recovery basis pro-
5 vided in paragraphs (1) through (5);

6 “(B) on the basis of the inpatient or out-
7 patient encounter rates established for Indian
8 Health Service facilities and published annually
9 in the Federal Register;

10 “(C) on the same basis as other providers
11 are reimbursed under this title, provided that
12 the amounts determined under paragraph
13 (c)(2)(B) shall be added to any such amount;

14 “(D) on the basis of any other rate or
15 methodology applicable to the Indian Health
16 Service or an Indian tribe or tribal organiza-
17 tion; or

18 “(E) on the basis of any rate or methodol-
19 ogy negotiated with the agency responsible for
20 making payment.

21 “(d) ELECTION OF REIMBURSEMENT FOR OTHER
22 SERVICES.—

23 “(1) IN GENERAL.—A qualified Indian health
24 program may elect to be reimbursed for any service
25 the Indian Health Service, an Indian tribe or tribal

1 organization, or an urban Indian organization may
2 be reimbursed for under section 1880 and section
3 1911.

4 “(2) OPTION TO INCLUDE ADDITIONAL SERV-
5 ICES.—An election under paragraph (1) may in-
6 clude, at the election of the qualified Indian health
7 program—

8 “(A) any service when furnished by an em-
9 ployee of the qualified Indian health program
10 who is licensed or certified to perform such a
11 service to the same extent that such service
12 would be reimbursable if performed by a physi-
13 cian and any service or supplies furnished as in-
14 cident to a physician’s service as would other-
15 wise be covered if furnished by a physician or
16 as an incident to a physician’s service;

17 “(B) screening, diagnostic, and therapeutic
18 outpatient services including part-time or inter-
19 mittent screening, diagnostic, and therapeutic
20 skilled nursing care and related medical sup-
21 plies (other than drugs and biologicals), fur-
22 nished by an employee of the qualified Indian
23 health program who is licensed or certified to
24 perform such a service for an individual in the
25 individual’s home or in a community health set-

1 ting under a written plan of treatment estab-
2 lished and periodically reviewed by a physician,
3 when furnished to an individual as an out-
4 patient of a qualified Indian health program;

5 “(C) preventive primary health services as
6 described under section 330 of the Public
7 Health Service Act, when provided by an em-
8 ployee of the qualified Indian health program
9 who is licensed or certified to perform such a
10 service, regardless of the location in which the
11 service is provided;

12 “(D) with respect to services for children,
13 all services specified as part of the State plan
14 under title XIX, the State child health plan
15 under title XXI, and early and periodic screen-
16 ing, diagnostic, and treatment services as de-
17 scribed in section 1905(r);

18 “(E) influenza and pneumococcal immuni-
19 zations;

20 “(F) other immunizations for prevention of
21 communicable diseases when targeted; and

22 “(G) the cost of transportation for provid-
23 ers or patients necessary to facilitate access for
24 patients.”.

Subtitle B—Medicaid**SEC. 211. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.**

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (64), by striking “and” at the end:

(2) in paragraph (65), by striking the period and inserting “; and”; and

(3) by inserting after paragraph (65), the following:

“(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State’s administration of the State plan under this title, so long as—

“(A) the term ‘meaningful consultation’ is defined through the negotiated rulemaking

1 process provided for under section 802 of the
 2 Indian Health Care Improvement Act; and

3 “(B) such consultation is carried out in
 4 collaboration with the Indian Medicaid Advisory
 5 Committee established under section 415(a)(3)
 6 of that Act.”.

7 **SEC. 212. FMAP FOR SERVICES PROVIDED BY INDIAN**
 8 **HEALTH PROGRAMS.**

9 The third sentence of Section 1905(b) of the Social
 10 Security Act (42 U.S.C. 1396d(b)) is amended to read as
 11 follows:

12 “Notwithstanding the first sentence of this section, the
 13 Federal medical assistance percentage shall be 100 per
 14 cent with respect to amounts expended as medical assist-
 15 ance for services which are received through the Indian
 16 Health Service, an Indian tribe or tribal organization, or
 17 an urban Indian organization (as defined in section 4 of
 18 the Indian Health Care Improvement Act) under section
 19 1911, whether directly, by referral, or under contracts or
 20 other arrangements between the Indian Health Service,
 21 Indian tribe or tribal organization, or urban Indian orga-
 22 nization and another health provider.”.

23 **SEC. 213. INDIAN HEALTH SERVICE PROGRAMS.**

24 Section 1911 of the Social Security Act (42 U.S.C.
 25 1396j) is amended to read as follows:

1 “INDIAN HEALTH SERVICE PROGRAMS

2 “SEC. 1911. (a) IN GENERAL.—The Indian Health
3 Service, an Indian tribe or tribal organization, or an urban
4 Indian organization (as those terms are defined in section
5 4 of the Indian Health Care Improvement Act), shall be
6 eligible for reimbursement for medical assistance provided
7 under a State plan by such entities if and for so long as
8 the Service, Indian tribe or tribal organization, or urban
9 Indian organization provides services or provider types of
10 a type otherwise covered under the State plan and meets
11 the conditions and requirements which are applicable gen-
12 erally to the service for which it seeks reimbursement
13 under this title and for services provided by a qualified
14 Indian health program under section 1880A.

15 “(b) PERIOD FOR BILLING.—Notwithstanding sub-
16 section (a), if the Indian Health Service, an Indian tribe
17 or tribal organization, or an urban Indian organization
18 which provides services of a type otherwise covered under
19 the State plan does not meet all of the conditions and re-
20 quirements of this title which are applicable generally to
21 such services submits to the Secretary within 6 months
22 after the date on which such reimbursement is first sought
23 an acceptable plan for achieving compliance with such con-
24 ditions and requirements, the Service, an Indian tribe or
25 tribal organization, or urban Indian organization shall be

1 deemed to meet such conditions and requirements (and to
 2 be eligible for reimbursement under this title), without re-
 3 gard to the extent of actual compliance with such condi-
 4 tions and requirements during the first 12 months after
 5 the month in which such plan is submitted.

6 “(c) AUTHORITY TO ENTER INTO AGREEMENTS.—
 7 The Secretary may enter into agreements with the State
 8 agency for the purpose of reimbursing such agency for
 9 health care and services provided by the Indian Health
 10 Service, Indian tribes or tribal organizations, or urban In-
 11 dian organizations, directly, through referral, or under
 12 contracts or other arrangements between the Indian
 13 Health Service, an Indian tribe or tribal organization, or
 14 an urban Indian organization and another health care pro-
 15 vider to Indians who are eligible for medical assistance
 16 under the State plan.”.

17 **Subtitle C—State Children’s Health** 18 **Insurance Program**

19 **SEC. 221. ENHANCED FMAP FOR STATE CHILDREN’S** 20 **HEALTH INSURANCE PROGRAM.**

21 (a) IN GENERAL.—Section 2105(b) of the Social Se-
 22 curity Act (42 U.S.C. 1397ee(b)) is amended—

23 (1) by striking “For purposes” and inserting
 24 the following:

1 “(1) IN GENERAL.—Subject to paragraph (2),
2 for purposes”; and

3 (2) by adding at the end the following:

4 “(2) SERVICES PROVIDED BY INDIAN PRO-
5 GRAMS.—Without regard to which option a State
6 chooses under section 2101(a), the ‘enhanced
7 FMAP’ for a State for a fiscal year shall be 100 per
8 cent with respect to expenditures for child health as-
9 sistance for services provided through a health pro-
10 gram operated by the Indian Health Service, an In-
11 dian tribe or tribal organization, or an urban Indian
12 organization (as such terms are defined in section 4
13 of the Indian Health Care Improvement Act).”.

14 (b) CONFORMING AMENDMENT.—Section
15 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B))
16 is amended by inserting “an Indian tribe or tribal organi-
17 zation, or an urban Indian organization (as such terms
18 are defined in section 4 of the Indian Health Care Im-
19 provement Act),” after “Service,”.

20 **SEC. 222. DIRECT FUNDING OF STATE CHILDREN’S HEALTH**
21 **INSURANCE PROGRAM.**

22 Title XXI of Social Security Act (42 U.S.C. 1397aa
23 et seq.) is amended by adding at the end the following:

1 **“SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PRO-**
2 **GRAMS.**

3 “(a) IN GENERAL.—The Secretary may enter into
4 agreements directly with the Indian Health Service, an In-
5 dian tribe or tribal organization, or an urban Indian orga-
6 nization (as such terms are defined in section 4 of the
7 Indian Health Care Improvement Act) for such entities
8 to provide child health assistance to Indians who reside
9 in a service area on or near an Indian reservation. Such
10 agreements may provide for funding under a block grant
11 or such other mechanism as is agreed upon by the Sec-
12 retary and the Indian Health Service, Indian tribe or trib-
13 al organization, or urban Indian organization. Such agree-
14 ments may not be made contingent on the approval of the
15 State in which the Indians to be served reside.

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

21 “(1) to be administered by such entity to
22 achieve the purposes and objectives of this title
23 under an agreement between the State and the en-
24 tity; or

1 “(2) under an agreement entered into under
2 subsection (a) between the entity and the Sec-
3 retary.”.

4 **Subtitle D—Authorization of**
5 **Appropriations**

6 **SEC. 231. AUTHORIZATION OF APPROPRIATIONS.**

7 There is authorized to be appropriated such sums as
8 may be necessary for each of fiscal years 2004 through
9 2015 to carry out this title and the amendments by this
10 title.

11 **TITLE III—MISCELLANEOUS**
12 **PROVISIONS**

13 **SEC. 301. REPEALS.**

14 The following are repealed:

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

17 (2) Section 712 of the Indian Health Care
18 Amendments of 1988 is repealed.

19 **SEC. 302. SEVERABILITY PROVISIONS.**

20 If any provision of this Act, any amendment made
21 by the Act, or the application of such provision or amend-
22 ment to any person or circumstances is held to be invalid,
23 the remainder of this Act, the remaining amendments
24 made by this Act, and the application of such provisions

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1 to persons or circumstances other than those to which it
2 is held invalid, shall not be affected thereby.

3 **SEC. 303. EFFECTIVE DATE.**

4 This Act and the amendments made by this Act take
5 effect on October 1, 2003.

○

The CHAIRMAN. In the interest of time, we are going to go ahead and start with our panel which includes Melanie Benjamin, chief executive, Mille Lacs Band Assembly, Onamia, MN; Buford L. Rolin, vice chairman, Poarch Band of Cree Indians, Atmore, AL; Myra M. Munson, Esq., Sonosky, Chambers, Sachse, Miller & Munson, LLP, Juneau, AK; and Mim Dixon, Dixon & Associates, Boulder, CO.

I read all your written testimony this morning. It will all be included in the record. If you would like to abbreviate or diverge from that written testimony, feel free to do so.

We will start with Ms. Benjamin.

STATEMENT OF MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND ASSEMBLY, ONAMIA, MN, ACCOMPANIED BY SAMUEL MOOSE, COMMISSIONER OF HEALTH AND HUMAN SERVICES

Ms. BENJAMIN. Good morning, Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Committee on Indian Affairs. I am Melanie Benjamin. I am the chief executive of the Mille Lacs Band of Ojibwe. Accompanying me today is Samuel Moose, who is the commissioner of Health and Human Services. I also brought summer youth as well. This will be their first opportunity to participate in this hearing.

The CHAIRMAN. Are those the young people back here?

Ms. BENJAMIN. Yes.

The CHAIRMAN. We are glad to have them here.

Ms. BENJAMIN. The Mille Lacs Band is a federally-recognized tribe of 3,570 members located in East Central Minnesota. As an elected tribal leader, I have an interest in the general direction of Federal Indian policy. I am greatly concerned with the dismal state of health across Indian country, and in particular, on the Mille Lacs Reservation.

My comments to the Senate Committee on Indian Affairs are provided from this perspective. At the outset, I wish to respectfully point out that I am not an expert on health care issues, nor on Medicaid or Medicare. There are individuals on this panel who are experts and possess the technical knowledge to more adequately address these subjects.

Today I will briefly discuss three topics as they relate to Medicaid and Medicare under Title IV of the Indian Health Care Improvement Act, sovereignty, the Federal trust responsibility, and Indian Health disparities. The access to health services under title IV provisions have a direct connection to the health disparities in Indian country and must be addressed by Congress.

When the Indian Health Care Improvement Act was first enacted in 1976, Congress recognized its trust responsibility toward the tribes to provide adequate health care. Throughout the subsequent amendments and reauthorizations of the act, one of the major underlying policies has been to provide tribes access to other Federal health care sources, like Medicaid and Medicare programs that do not face funding limits like our Indian Health Service programs do.

The intent was and is to improve our health status through that access. Since then Medicaid and Medicare reimbursement to tribes,

including the Mille Lacs Band, have become a significant source of revenue for our health care programs and operations.

Over the last 15 years, the Mille Lacs Band has actively participated in the formulation of tribal self-governance policy. We were one of the first 10 self-governance tribes. We participated in the original demonstration project and the writing of the permanent acts for BIA and Indian Health Service self-governance. We have also been on the rulemaking committees for the implementation of self-governance laws.

Currently, the Mille Lacs Band is an active member of the Tribal Self-Governance Advisory Committee that advises Federal agencies on Indian policy matters affecting the self-governance tribes. The Mille Lacs Band has supported and advocated for self-governance laws because our philosophy is that we should be free to govern ourselves and develop our own policies in the administration of our tribal programs. We should not be entangled by Federal or State bureaucracy. To us, developing our own policies is an important exercise of sovereignty.

There are three principles that the Mille Lacs Band of Ojibwe considers when analyzing Federal programs. First, we assert that our primary relationship is with the Federal Government. Second, we retain all sovereignty not expressly taken away. Therefore, we should have the ability to control funds reserved for us under Federal law. Third, we should have equal access to the same funding avenues as States. This third principle raises the fundamental flaw of the Medicaid and Medicare programs and the treatment of tribes.

It is my understanding that the design of the Medicaid and Medicare programs is a Federal-State collaboration. The problem is that tribes do not fit into the picture at all. This design flaw makes it very difficult to meet criteria for receiving reimbursements.

An example is that counties receive an administrative match from the State for their administrative costs, while tribes cannot. According to the Mille Lacs Band of Ojibwe's Commission of Health and Human Services, our inability to recover the administrative match demonstrates that tribes do not have equal access to Medicaid and Medicare reimbursements.

The reason is that States determine how their block grants will be distributed under their own guidelines. As a result, the Mille Lacs Band and many other tribes lose out on potential and critical avenues of funding we desperately need. Others on this panel have addressed this and other legal barriers more specifically, but from a tribal leader perspective, it is clear that States and managed care systems have predominance over tribes under Medicaid and Medicare.

Clearly, the establishment of Medicaid and Medicare entitlement programs happened at a time in history when the Congress did not focus on tribal sovereignty. However, today tribes are treated as governments in Federal legislation and tribal sovereignty is recognized. Indian people are provided direct access to Federal programs and funding.

The Mille Lacs Band of Ojibwe receives direct funding for our Self-Governance Indian Health Service annual funding agreement. But when it comes to Medicaid and Medicare programs, it is a dif-

ferent situation. The process of devolution, where Federal funds in the form of block grants are provided to the States who then distribute those funds under their guidelines, has created a framework that leaves the tribes unable to access needed funds.

It is time to change the Medicaid and Medicare provisions under title IV of the Indian Health Care Improvement Act to reflect the new enlightened view of tribal sovereignty and provide tribes more access to health care services as the act was originally intended. Through our treaties, Federal statutes, executive orders, and court decisions, a Federal trust responsibility has been established and recognized over the course of dealings with tribes.

The Mille Lacs Band of Ojibwe signed several treaties with the United States and the provision of proper health care became an expectation of the Band and an obligation of the Federal Government. In addition, the Snyder Act of 1921, the Transfer Act of 1954, the Self-Determination Act of 1975, the Indian Health Care Improvement Act of 1976, as well as the enactment of the Indian Health Service Self-Governance Act, all evidence the trust obligations that flow to the tribes from the Federal Government for the provision of health care.

In spite of the clear legal duty created by these Federal statutes, the Federal obligation to provide adequate health care to tribes has never been properly funded. Historically, this insufficient funding has interfered with our ability to provide comprehensive health care to Mille Lacs Band members. According to IHS estimates, the Mille Lacs Band, and all other tribes in our region, are funded at approximately 30 percent of need. This means more than two-thirds of our need is not being met and explains why the status of Indian health on the Mille Lacs Band Reservation, and many other reservations, is so poor.

I am told that the Federal Government spends nearly twice as much for a prisoner's health care than it does for Indians. This fact is an example of why our health status is at the bottom of every disease category. It seems ironic that Indian health care, through the Indian Health Service, is not an entitlement for Indian people when tribes essentially pre-paid for our health care by ceding millions of acres of land to the Federal Government.

It seems more ironic that the tribes have problems accessing the Federal entitlement programs like Medicaid and Medicare which were designed for all State citizens. This funding disparity becomes a matter of fairness and equity because Indian people are also citizens of the States in which we reside. It is only logical that we should have the same access to the same services as do other non-Indian citizens.

Given that we have been historically under-funded for our health care needs, and tribes likely will not receive funding for the level of need in the next appropriations cycle, the Federal trust responsibility needs to be taken seriously and changes made to allow tribes full participation in the existing entitlement programs of Medicaid and Medicare. It is fair and it is right.

Finally, I am not going to cite the long and tragic list of statistics that tell the story of health disparities throughout Indian country. Instead, I will talk about my own Reservation. Diabetes is a serious problem in the Mille Lacs community. I do not know of one

family without diabetes among one of their family members. For many our Band members, it is not a matter of if they get the disease, but when. Band members are losing their vision. They are losing their limbs. Many are so close to needing kidney dialysis treatments.

More alarming is the chronic health conditions occurring in our children and our youth. They are our future. I have serious concerns for their long-term health and longevity. I do not have answers but I do know that adequate and comprehensive health care is absolutely critical to preserving our tribal communities. We are fighting to protect our members' lives on our reservations and in our communities.

If Congress makes the necessary changes to Title IV of the Indian Health Care Improvement Act, and provides more access to Federal health care services and funds, it will at least give us another weapon in the war against health disparities.

Thank you for this opportunity to testify. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

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

The CHAIRMAN. Thank you, Ms. Benjamin.

Senator Johnson, I do not know how tight your schedule is. Do you have a statement?

STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Mr. Chairman, I just commend you for holding this very timely hearing. There are few areas where we have a greater crisis than in health care as we go about the debate on Medicare and Medicaid within the context of prescription drug coverage. I think that we have made some real progress on the Senate side, but it is essential that we continue to be closely consultative with the tribes. I think you have an excellent panel here.

I am going to have to excuse myself for some conflicting obligations that I have, but I will be examining the testimony closely and look forward to working with you and other members of the committee to see what we can do. The overall level of funding, of course, is the first problem. The IHS is funded at roughly half of what they ought to be funded.

But even beyond that, I think it is proper that we focus on the role of Medicare-Medicaid third-party payment mechanisms and what we do to better utilize those resources to live up to our obligations in Indian country.

I thank you very much.

The CHAIRMAN. For the panel's information, members will be coming and going. Some will not be here. It does not mean they are not interested in the issue. Every one of us is over-scheduled with two or three things to do at the same time. It comes with the territory here. Please understand why some members are not here.

Let us go ahead with Buford Rolin. Thank you for being here.

**STATEMENT OF BUFORD L. ROLIN, VICE CHAIRMAN, POARCH
BAND OF CREEK INDIANS, ATMORE, AL**

Mr. ROLIN. Thank you, Senator Campbell.

Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Committee on Indian Affairs, I am Buford Rolin, Vice Chairman of the Poarch Band of Creek Indians from Atmore, AL. I serve as an elected member of the National Indian Health Board representing the Nashville area. It is indeed an honor for me to come before you this morning to offer this testimony on the reauthorization of the Indian Health Care Improvement Act.

As you know, the Indian Health Service's National Indian Health Board serves all federally-recognized tribes throughout the Nation. We have a membership of 12 members that are elected to the Board by their respective areas. Our goal is to advocate for Indian people, not only in the budgetary area, but health issues throughout.

I would like to commend the testimony of chief executive officer Melanie Benjamin and her concerns. She has expressed them well. I know the other panelists will have equal concerns that they will talk about.

Given the two previous hearings of the committee that was held during the 108th Congress, I am going to be brief this morning. I realize that the members are quite aware, as you have just stated, about the needs of the health care of the Indian people, the reauthorization, and how important it is in the Indian Health Care Improvement Act. We realize the political realities that are facing Congress, and we appreciate the fact that you are holding these hearings this.

Let me talk a little bit about the process of what has taken place over the years since 1999 with the first bill that we introduced to reauthorize the Indian Health Care Improvement Act. In 1999, the National Steering Committee was formed by the Indian Health Service. It represented tribal leaders throughout the Nation as well as members from the organizations and urban areas.

Over the last several years, the NSC has worked closely with Indian country, the Administration and Congress, and the Indian Health Service to develop amendments to the Indian Health Care Improvement Act. Let me begin first by talking about the Centers for Medicaid and Medicare services.

At the request of the CMS, we have established a tribal technical work group that has been representative of Indian people throughout this Nation. The TTAG was formed in 2001 and consists of tribal leaders, area Indian health boards, and designated national tribal organizations.

The activities of the TTAG are coordinated through the Intergovernmental and tribal Affairs Office within CMS. The TTAG has forwarded several recommendations to Congress and CMS regarding recommended changes to the reimbursement methodologies in place for the Indian Health Service, tribal health programs, and urban Indian problems.

The TTAG is very adamant about its position that any reforms in Medicare, medicaid, or CHIP programs must allow for tribal al-

location or other direct funding mechanisms that authorize Indian health program access to CMS.

The TTAG has also worked very closely the NSC to develop the changes in Title IV of the Indian Health Care Improvement Act, as reflected in H.R. 2440, which include the most recent NSC recommendation.

As the committee is well aware, the Indian Health Service lags far behind other segments of the population and has failed to keep pace with inflation as far as health care is concerned. Current Indian Health Service funding is so inadequate that less than 60 percent of the health care needs of American Indians and Alaska Native people are being met.

In order to address additional health care resources, Title IV of the Indian Health Care Improvement Act is critical to address the Medicare-Medicaid and other third party reimbursements, as Chief Executive Officer Benjamin has stated this morning.

It is one of the most important provisions of the Indian Health Care Improvement Act. It makes IHS hospitals eligible for Medicare reimbursements and facilities eligible for Medicaid reimbursement. Title IV also makes it possible for Medicare and Medicaid eligible American Indians and Alaska natives to use these benefits.

Since the passage of the Indian Health Care Improvement Act in 1976, Medicare and Medicaid payments have become sources of income for tribal programs, so much so that in fiscal year 2002, \$460 million was collected for these services. This amount enhances the resources available already to hospitals and clinics' budgets by 30 percent. We are indeed appreciative of that.

But in order to further improve the ability of Indian country as far as health providers to access third party resources, the NSC has developed several changes to title IV that was indicated in S. 212 and continues through S. 556. I would like to note that S. 556 introduced to Congress is identical to S. 212. Therefore, many of the concerns raised in regards to S. 212 remain.

In response to those concerns, however, the National Steering Committee has revised the recommendations for reauthorization. The changes are reflected in H.R. 2440. By the way, that bill was introduced June 11, 2003.

I think it is quite helpful to point out that the Senate Committee on Indian Affairs and the House Resources Committee's hearing on the Indian Health Care Improvement Act last week indicates the cooperation and the spirit of the two houses to support this reauthorization. H.R. 2440 reflects several changes made to the original tribal proposal as introduced in 1999. Those changes listed have come about and we will see that in H.R. 2440.

There are four areas that I would like to quickly talk about that we have been removed from the previous legislation. One is the Qualified Indian Health Program. This provision has been removed. We have requested that a provider type with Indian health programs appear, such as Medicaid, so that we can more fully exercise our statutory rights in that aspect.

Secretary Thompson expressed his concern for that in S. 212. His concern was that over a 10-year period it would cost in excess of \$3 billion. However, in place of the QIHP proposal, tribes are requesting that the Secretary prepare a program or a report that

would, in fact, examine whether these payments under the current methodologies are sufficient to continue to be applicable as a most favorable provider under the Social Security Act. The current all-inclusive rate certainly is appreciated, and we would hope that in this process none of that would be discontinued.

Another concern that the Secretary had, of course, was the extension of the 100 percent Federal Medical Assistance Percentage. Tribal leaders agreed to delete this provision as well. The Centers for Medicare and Medicaid Services requested that be done. The States are very supportive of the 100 percent FMAP expansion. Secretary Thompson's concern was the cost of \$2 billion over a 10-year period.

A third area of his concern was the waiver of the Medicare late enrollment penalty as far as Part B of Medicare is concerned and the barriers that it may create as far as giving Indians the opportunity to enroll late as opposed to other enrollees within the Medicare programs. Tribal leaders reluctantly agreed to remove that factor as well.

Finally, an area of concern that we had, and the Secretary objected to, was the fact that tribal leaders had asked for, and called for, regulations in a negotiated rulemaking process. Our concerns here were relative to the complexity of the Social Security Act and to having to negotiate a rulemaking process. In response to this concern again, tribal leaders eliminated the Social Security Act changes from the bill's negotiated rulemaking provision.

We believe the changes to the original tribal proposal submitted in 1999 significantly reduces the bill's Federal budget impact. S. 212, or its identical bill, S. 556, as it was scored in 2001, has a Federal budget impact of \$6.9 billion. With the deletion of QIHP and the FMAP, the score reflects a 70-percent decrease.

We request, and ask this committee, to submit a request to the Congressional Budget Office to either score S. 556, without the above-mentioned provisions, provide a fiscal budget impact on H.R. 2440.

It has been my pleasure to brief this committee on the concerns that the National Indian Health Board has relative to the Indian Health Care Improvement Act. As I have been involved, along with other tribal leaders, including Chief Executive Officer Benjamin and the other panelists here this morning, we will continue to stay involved to make sure that this Act hopefully will be passed this year.

Further, we request that any concerns regarding this legislation are raised in a timely manner so that passage of the bill will occur during this session and there are no delays that would jeopardize the passage of this bill.

I thank you for your time. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

[Prepared statement of Buford Rolin appears in appendix.]

The CHAIRMAN. Thank you, Mr. Rolin.

Ms. Munson.

**STATEMENT OF MYRA M. MUNSON, ESQUIRE, SONOSKY,
CHAMBERS, SACHSE, MILLER & MUNSON, LLP, JUNEAU, AK**

Ms. MUNSON. Thank you, Mr. Chairman.

The last time I had the privilege of testifying before this committee was in the late 1980's when I was still commissioner of Health and Social Services for the State of Alaska. Since joining the law firm I am a member of now, I have had the opportunity to work with tribal leaders and tribal health providers on every major health reform initiative that has been discussed in the Congress, and since 1998 when the work began on the reauthorization of the Indian Health Care Improvement Act.

It is fundamental that the United States owes a duty to Indians to provide them with health care. Everything flows from that. It is equally fundamental in the decisionmaking that that health care, in order to be delivered in a responsible way, must be culturally competent.

That requires not merely that individual Indians have access to health care, which most do not, at least in any way comparable to that of other citizens of the United States and the States, but it is important that the health care they have access to is that operated by their own tribes or the Indian Health Service, carried out to the extent possible to Indian people, and managed by Indian people.

Indian people and Indian tribes expected that the duty of the United States would be satisfied by providing them with direct appropriations to the Indian Health Service and eventually down to the tribes through the Self-Determination Act. Congress has not been able to effect the appropriations necessary to meet any level of health care for Indian people comparable to that, provided even to Federal employees, let alone to other Americans.

Instead, in 1976 when the Health Care Improvement Act was first authorized, Congress, realizing it could not meet the needs exclusively through direct appropriations, chose to authorize the Indian Health Service and tribes eventually as they took over the programs to bill for certain services provided to Medicare or Medicaid eligible Indians, to bill those programs and recover those revenues.

That made a fundamental shift and one which has been very difficult for tribes and for their members to absorb. It essentially made many Indians into welfare recipients when they had never been before. It made them apply for benefits through the Medicaid program in order to have access to the very care they had been promised and for which they had ceded their lands.

However, time passes and Indian people and Indian tribal leaders are pragmatic. Indian Health Services had to be pragmatic about this. The resistance to participating in those programs has had to be overcome simply to make enough money available to try to begin to provide for the needs for health care.

Tribes and the Indian Health Service have worked to become competent billers of the Medicare and Medicaid programs and to be able to participate without losing the integrity of the very special programs that they offer.

The Indian health system is truly the only system of health care that exists in the United States. For all the promise of managed

care, somehow it would bring a preventative focus to care; it would be a birth-to-death kind of model. In fact, it is as profit-driven as all other health care in the United States and tends to focus on illness and not on health, on response and not on prevention.

The Indian health system is fundamentally different than that in that it is truly a birth-to-death program. The people who are running health programs, and many of the programs that I work with, were born in the hospitals that they now operate and that they now run. Their children were born in those hospitals. They expect their great-grandchildren to be born and cared for in a program that they operate. That is not an expectation that those of us who rely on the private sector health care system care enjoy. But to make that real, of course, there must be adequate financing.

The Medicare and Medicaid programs are complex and not the things that are typically dealt with by this committee or the Resources Committee in the House. They are relatively foreign. You may have experienced this yourself, or you may have talked with someone who has had to assist an elder parent in applying for Medicare or making sense of their benefits, or assisted someone in applying for Medicaid in order that they could be in a nursing home or get other care that they need—these are difficult programs to participate in.

In my written testimony, I have described very briefly the basics of those programs. I think for those of you who are, in fact, familiar with Indian people, and the way in which they live, when you read about those programs, you will see the way in which they diverge.

However, the Medicare and Medicaid programs are rife with special exceptions. There is a tendency to believe that it is all one program and it exists in exactly the same way for everyone. Fundamentally not true. There are exceptions built in throughout Medicare and Medicaid to assure that special populations will get some level of care to guarantee their access, and that certain kinds of providers will continue to exist even as the rates get cranked down in those programs to manage the cost increases.

So there are federally-qualified health centers, rural health centers, and critical access hospitals, children's hospitals, and cancer treatment centers. The list goes on and on of various kinds of specific providers, each one of which, if you meet all the finely-tuned rules, you get a special level of compensation under the program different than applies to others.

Fundamentally, as we worked on trying to revise the Medicare-Medicaid provisions and access by the Indian Health Service and tribes, we kept that in mind. We recognized that the duty to provide health care to Indians is fundamental. The existence of the Indian Health Service and of tribal health programs is fundamental. Medicaid and Medicare should recognize those special provider types.

As Mr. Rolin said, the Steering Committee agreed, reluctantly, to drop the qualified Indian Health Program as a new and special provider type in order to try to move this bill forward. Instead, what we have done is try to tailor very narrow provisions to other parts of Medicaid where there are special compensation or reimbursement rules or Medicare to permit the kinds of activities that

are so essential on reservations and in Indian communities in which health care is being provided.

For instance, there is a provision that allows visiting nurse services to be reimbursed, provided they are provided through a rural health center in a setting which is a shortage area for home and community-based care services. There are lots of rules attached to that. We ask that the same kind of visiting nurse services be reimbursed when they are provided in any Indian Health Service program without having to go through becoming a rural health center and proving you are in a shortage area. We know there are those shortages.

I have provided for the committee comments on H.R. 2440 provisions. Those reflect the best drafting. I can say with some great humility, I wrote much of what is in S. 556 regarding the Social Security Act provisions and the title IV provisions. They were written conceptually.

I could spend my lifetime and never penetrate to the depths of the Social Security Act and get an amendment quite right. We were blessed with the assistance of Representative Young to have an opportunity to work with House Legislative Counsel who assisted us in turning our concepts into real Social Security Act amendments. We encourage you to look at those and less at the S. 556 provisions.

There is a side-by-side analysis that has been provided to committee members so that you can track from S. 556 to the House bill and understand what is left and how it has been redone. There is also a section-by-section analysis which is attached to my testimony.

I want to mention basically six principles that drive the kinds of amendments. They are first to improve access to Medicare and Medicaid enrollment. It is not, as I mentioned earlier, a natural thought for an Indian elder to seek to apply for Medicare. Many Indian elders are not eligible for Medicare. They are not eligible for Social Security because they did not work in jobs that participate in Social Security during their work years.

But for those who are, it is not natural for them to consider enrolling in part B and using up \$700 a year of their limited income to pay part B premiums. Applying for Medicaid is certainly not something they think about even though they may be living in poverty—because they are used to caring for themselves. They expect the Indian health programs to provide the health care they need.

Those programs are not accessible because people resist applying and because in many States services and access by Indian people to the programs operated by the State is not readily available. Some of that is a matter of direct policy by States, of where they locate their services, and some of it is because of the sheer remoteness of where Indian people live in relationship to State services. Finding ways to involve tribes meaningfully in those activities is an important feature of the act so that the rights of Indian people to participate in those programs can be protected.

In addition, reducing co-payments, co-insurance, and deductible obligations without reducing the reimbursement to the tribal or Indian Health Services program also helps to overcome the barrier to access to those programs.

Second, and I have mentioned this before, Indian health programs should enjoy the same kind of special consideration in the Social Security Act provisions that other kinds of health care programs, like federally-qualified health centers, or rural health centers, enjoy. You should not be taken in when somebody says, "Oh, they are trying to create an exception." There are a thousand exceptions.

The Social Security Act provisions on Medicare and Medicaid are basically about two general rules. Everything else is an exception to those rules. We are simply looking for some of the same kinds of things. Nothing we have asked for is fundamentally different than is available for some other kind of provider.

Third, we are looking to minimize administrative barriers. Mr. Rolin spoke to the fact that currently most of the Indian health programs are reimbursed on an encounter per-day rate. We look to maintain that rate while a study of reimbursement is carried out to ensure that any changes in those reimbursement methodologies are carried out in a way that will minimize administrative burdens and will control the costs of trying to build new billing systems, and to respond to the administrative requirements of those programs.

Fourth, we want to encourage cooperation with the States. Medicaid is a partnership with States that cannot be effectively carried out by tribes without a good relationship with the States. We look for additional consultation on their part, and in some other provisions to find ways to improve the relationships.

Among those is to reduce the role of the States in licensing tribal facilities and tribal providers so long as they meet the quality standards imposed by the Social Security Act. It basically would put the tribal providers in the same position that the Federal Indian Health Service providers are, vis-a-vis State regulation. We look to try to achieve that more uniformly.

Finally, we want to improve communication by the formation of a technical assistance group in which people like myself and Mim Dixon, along with health care providers from tribal programs and others can work on behalf of tribal leaders, and in direct interaction with CMS, to work through issues as they arise so that when the Department of Health and Human Services is making policy changes, they do so fully aware of the consequences of them. What happens now all too often is that they make the change and it is only months down the road that the impact of that change becomes apparent and we all scramble to find a way to fix it.

I join with the others in encouraging that this committee keep this bill intact, that it endorse these provisions, and that it work closely with other committees of the Senate and the House who have jurisdiction over certain of these provisions relating to the Social Security Act to ensure that they will give those requests the serious attention that they are due. It is easy to lose small changes. In an environment in which you are trying to make changes as massive as adopting Medicare prescription drugs, the very tiny nature of what we are asking for should not stop serious consideration of them.

Thank you very much. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

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

The CHAIRMAN. Thank you, Ms. Munson.

By the way, do not worry about not getting things right. We work year-around here and if you could read our mail, we never get things right. We just have to keep trying. That is why you never get rid of us, I guess.

Before I go on, I did not know what Senator Murkowski's schedule is, particularly since Ms. Munson is from Juneau.

Do you have any opening statement or comments before we go on? I do not know if you have to leave.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I will be leaving in about 15 minutes, but I did want to hear the testimony of Ms. Munson and welcome her as a constituent. I also want to welcome a former constituent, Ms. Dixon. I am looking forward to her testimony. I understand she is from Fairbanks, as I am. We share a lot there.

I just wanted to listen to the comments this morning and thank you, Mr. Chairman, for continuing on this very important issue of the reauthorization of Indian health.

The CHAIRMAN. Thank you.

Ms. Dixon, please proceed.

**STATEMENT OF MIM DIXON, DIXON & ASSOCIATES, BOULDER,
CO**

Ms. DIXON. Thank you, Chairman Campbell and Senator Murkowski, tribal leaders, and honored guests today.

There has been a lot of talk recently about modernizing Medicare and, in a way, the proposed Title IV of the Indian Health Care Improvement Act, and the proposed amendments to Medicaid, Medicare, and the Social Security Act, could be considering modernizing Indian health care. As we know, this is not an appropriations bill and it will not provide the funding to bring programs and facilities up to standards.

So when I talk about modernizing Indian health care, I am not talking about the delivery of services. Rather I am talking about modernizing the legal and regulatory framework that allows the Indian health programs to bill Medicaid, SCHIP, Medicare, and private insurance, and to be paid for the covered services that are provided to mutual beneficiaries.

Title IV and the Social Security Act amendments are needed to respond to changes that have occurred in health care delivery in our country in the past decade. Just a few years ago there was no Medicaid managed care. There was no SCHIP. There was no Medicare Part C or D or E. In most States, tribes have not been included in the planning for these changes in Medicaid, or to the development of SCHIP programs.

It is difficult for Indian health care to interface with the Medicaid, SCHIP and Medicare of today. Indian health programs are unique in many ways that make it impossible for many Indian health facilities and programs to meet the usual requirements to become providers under managed care programs.

Yet the Indian Health Service beneficiaries who are enrolled in managed care programs under their Medicaid and SCHIP pro-

grams will go off-plan to seek care at their Indian health care facility. It is essential that they have that unrestricted choice and that the Indian health facility can bill and be paid for the services it provides.

Provisions in the Indian Health Care Improvement Act also allow tribes to take advantage of some of the opportunities provided by managed care. For example, they could use funds from the Indian Health Service as to purchase managed care plans or other insurance programs for their beneficiaries. The measures would also require States to allow Indian health providers to service case managers for American Indian and Alaska Native Medicaid beneficiaries.

Despite the increasing reliance of Indian health programs on third-party collections, many American Indians who are eligible for Medicaid and SCHIP are not enrolled in those programs. To remedy this situation, this bill authorizes funding for tribes for outreach services. The bills would also eliminate financial barriers to enrollment in Medicaid and SCHIP, such as premiums, deductibles, and co-pays.

Many of the issues relating to Indian health care financing are extremely complicated. Tribes have recognized that there is a need for a national Tribal Technical Advisory Group to work closely with CMS to resolve problems as they arise. To operate effectively, this TTAG must be authorized in law. The TTAG will be essential for helping to implement the provisions in Title IV of the Indian Health Care Improvement Act, and for all the proposed changes in Medicare under the proposed prescription drug legislation and proposed Medicaid reform.

In closing, it is important to remember the purpose of this legislation. At the heart of the provisions in title IV is enhancing access to care for American Indians and Alaska Natives, protecting their rights to choose their health care providers, and assuring that Indian health care facilities get paid when they provide services under Medicaid, SCHIP, and Medicare to those beneficiaries.

I have submitted written testimony which provides greater detail on these points. Thank you. I would also ask that my written statement be made part of the record of this hearing.

The CHAIRMAN. Without objection, so ordered.

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

The CHAIRMAN. Thank you, Ms. Dixon.

Let me ask a couple of questions. Let me start with Ms. Benjamin. Thank you for being here.

I have been a big supporter, as you know, for years of self-governance. It seems to me that the tribes, if they have the capability, should be offered that opportunity. In most cases they do a better job than the Federal Government could have done.

But with that in mind, I guess there are some things that probably ought to remain with the Agency. Let me just ask you a couple of things on that. With that thought in mind, what is your view on Secretarial oversight for the tribal direct billing program?

Ms. BENJAMIN. That's a hard question.

The CHAIRMAN. Yes; I know. That is why I asked you. [Laughter.]

Do you think tribes could do that better than can be done through the Agency?

Ms. BENJAMIN. We know what our need is for our membership. I think we can address the health disparity issues better than an outside entity doing that. So I would support that tribes would have that authority to do that.

The CHAIRMAN. Your testimony also includes a concern that tribes are usually not consulted in the design of the State Medicaid programs. It is not unusual, unfortunately. We hear that very often here in the committee that there is a lack of good in-depth consulting with the tribes before decisions are made.

How do we encourage tribal State collaboration in the design of health insurance programs so that they are inclusive of Indian people's needs?

Ms. BENJAMIN. I guess I can look at our example. Currently what we have for our membership is called a "Circle of Health." We provide some health care opportunities for all of our members, regardless of where they live in the United States. There is a process that they have to go through, of course. Our goal is to make sure that people that may not live on the reservation, that live in different States, and do not have access, that we are providing a service to them as well.

The CHAIRMAN. Do you do that through the mail? Do you offer advice, say, of 500 miles away and cannot get home to the clinic?

Ms. BENJAMIN. We send them applications where they would be able to get some insurance in their State. We help pay the premiums for that, to get that done. We want to make sure that our membership is not forgotten, if they live elsewhere beside the reservation.

The CHAIRMAN. That is a great idea. Has that been pretty successful?

Ms. BENJAMIN. It is successful. We still have a lot of folks that still have not utilized that program. We are continuously trying to educate them and the opportunities through our mailings or newsletters. We also make sure that they know what services are available.

Also, what we are doing with the State of Minnesota is that we try to partner in any way we can. Currently we have some discussions with the TANF program to provide services for Indian people in the Minneapolis-St. Paul area. We also feel that we can show more compassion to Indian people, to our own tribal members or whoever, to get them to become more self-sufficient because of our cultural backgrounds. We can relate to some of those issues, we feel, in a better way than the State or county agencies that are out there.

Those are two examples of what we are trying to do. We want to provide a system that we can hopefully improve lives for membership of our own tribe and other Indian people, even though they do not live directly on the reservation.

The CHAIRMAN. You mentioned that your tribe has difficulty collecting third-party reimbursements, and the little you do collect often goes to meeting health care needs of your tribal members. What are the most serious impediments to preventing the tribe from collecting third-party reimbursements?

Ms. BENJAMIN. I would like to refer that question to Samuel Moose, the Commissioner of Health and Human Services because he administers that. Can you assist me, Sam?

Mr. MOOSE. We are always negotiating with the State and through our State liaison some opportunities within the various programs. Some of the difficulties that we run into is that the State delegates some of that authority to the local county agencies where they were negotiating those rates and opportunities. We have had difficulties in the past.

The CHAIRMAN. Do they just refuse to negotiate? Do they drag their feet?

Mr. MOOSE. Yes; they drag their feet. Some of them come to the table. We really do not make any progress with the issues. There is always a history. There is always something that comes up that somehow creates barrier.

The CHAIRMAN. It is called jumping through hoops.

Mr. MOOSE. Yes.

The CHAIRMAN. It is not uncommon, I guess.

Vice Chairman Rolin, you have put a number of years of dedication to improving the health of Indian people. I want to commend you for that. You have been in here a number of times testifying on their behalf. I thank you for that.

On the Federal medical assistance percentage, I understand that the National Steering Committee decided to remove the 100 percent FMAP expansion provision in S. 556 in response to the Administration's concern that it would be too costly; is that correct?

Mr. ROLIN. That is correct.

The CHAIRMAN. What cost estimates were included in that decision?

Mr. ROLIN. Myra might be able to answer that. She has handled that technical portion.

The CHAIRMAN. We call that passing the buck around here, Myra. Go ahead. [Laughter.]

Mr. ROLIN. That has been her area of expertise.

Ms. MUNSON. If Congress would pass the buck, we would have no problems here. [Laughter.]

The CHAIRMAN. Bucks, plural.

Ms. MUNSON. Many, many bucks. The truth is we really do not know. What we do know is that they came up with an estimate of \$2.48 billion for the 100 percent FMAP. We believe that that is a substantial over-estimate of increased costs since we believe that States that currently claiming 100 percent FMAP for a wide variety of activities that they believe, and I think correctly, are already authorized as "through the facility."

A significant amount of the FMAP issue arises out of the difference of interpretation of that phrase, "through the facility," with tribal health programs and the States interpreting it to mean not only the things provided in the building, but things which may be referred out that have to be purchased from other providers. They should also be entitled to that 100 percent FMAP. We think that CBO has over-estimated the number, but we do not have the benefit of having any details so we cannot tell you exactly in what ways.

The CHAIRMAN. I see.

Mr. ROLIN. Senator, if I might add, you noted in my testimony also the States support that. They believe this would be a direct support as far as funding for tribes. They have been most supportive in that aspect.

The CHAIRMAN. We often hear that States deny health care to Indian people by saying it is a Federal responsibility. Is the NSC aware of cases where States have refused public health insurance coverage for eligible Indian people because of that concept?

Mr. ROLIN. I do not know of any. Ms. Dixon, are you familiar with any? I am not aware of any. I know my State has not.

The CHAIRMAN. Ms. Dixon.

Ms. DIXON. I think it is a matter of degree. It is not as black and white as that. I think that there is a higher level of cooperation with the State looking for ways to enhance and support the Indian health system when there is 100 percent FMAP and they are not trying to conserve State funds and they realize that the Federal are there.

For those services where there is not 100 percent FMAP, Medicaid directors tend to take the most conservative approach in terms of allowing tribes to carry out their mission with Medicaid funding.

The CHAIRMAN. Okay.

Ms. Munson.

Ms. MUNSON. If I could, Mr. Chairman, I think the denial plays out in one other way. I think any Indian person who gets their application in and manages to fill it out completely will be granted their eligibility if they satisfy all the conditions. The trick is: Will they ever get the application? Will they understand it? Will they get it completed? Will they meet the deadlines for personal interviews or whatever other hoops they may have to jump through to get it considered? Will, in fact, it be returned to them because there is something missing? Will they have had difficulty getting access?

We believe, and there is pretty good demonstrated evidence of this, that even in States that cooperate, Indian people are substantially under-represented in the Medicaid rolls compared to the level of poverty in Indian country. We think there are many barriers; most of them subtle.

The CHAIRMAN. Including educational problems. Sometimes Indian people do not have the educational opportunities and when they have to fill out some of these complicated Federal or State forms, they are already at a disadvantage.

Ms. MUNSON. Absolutely.

The CHAIRMAN. Ms. Dixon, we are dealing with managed care. You hear it all the time here in Congress, as you probably know. It seems to be the new rage. It seems to be the way we are going. But we do get some feedback that one size does not fit all, particularly in the difference between rural America and urban America. But I think also that might apply to the problems that many Indian people face, and that is cultural differences.

What are your recommendations to try to improve the health care system from a culturally-sensitive aspect for Indian people?

Ms. DIXON. That is a really good question. First, let me say that in essence the Indian health system is a culturally-sensitive managed care system. The issue is not so much the cultural sensitivity within the Indian health system, it is forcing Indian people to en-

roll in managed care plans that are operated by the State under Medicaid. And now with the revisions to Medicare that we are talking about, that is a potential there as well. It has not been so much Medicare up to now, as Medicaid.

Then forcing them to enroll in a Medicaid managed care plan for which the Indian Health System is not a provider. Then they are into a health care system that is off the reservation, or outside their communities, where people have little knowledge of the culture, where there are not people who speak the language, where people do not understand the living conditions. Often times facilities are very hard to access because they are far away. They are defaulted to a facility that might require a great deal of transportation to get there. They do not have the vehicles and the transportation.

What we have recommended—and what tribes have been recommending ever since the National Indian Health Board did its study of the nine State Medicaid programs that have gone into managed care, that had a significant Indian population in those States—is that Indian people be exempted from mandatory enrollment, that States keep a carve-out for Indian health that is paid for on a “fee-for-service.” We call it “fee-for-service,” but it really is not. It is called the “encounter rate” or the “all-inclusive rate.” Sometimes it is the “OMB rate” or the “IHS rate.” It is not exactly “fee-for-service,” but it is not the capitated managed care payment.

Also, Indian people should be allowed to go to their local Indian facility, if that is what they choose. If they choose to use another facility under Medicaid, they should be allowed to do that as well. But they should not be penalized, and the Indian health facility should not be penalized if a Medicaid recipient chooses to use their local tribal or Indian health care facility.

The CHAIRMAN. I agree.

Ms. Benjamin.

Ms. BENJAMIN. I wanted to comment on the cultural sensitive way of how some of our people deal with the providers. Many of our elders' first language would be Ojibwe. There is that communication barrier sometimes with the providers.

What we provide is traditional healers. They then have a comfort level dealing with someone that can speak and understand their language. Our issue with the traditional healers is that they are not recognized. We are not included in the billing process when we use traditional healing for our membership.

The CHAIRMAN. I think some other tribes have had quite a bit success with that, too. I think the Navajos do that, not only with working with the State for health care but such as surgery, for instance. I understand that they have spiritual leaders that understand the traditional healing ways of the Navajos who work with the doctors. I think that is a terrific idea.

I have often wondered if it creates a liability issue or what is sometimes called the unintended consequences of doing something. I wonder if there is something in there that comes around to haunt you later on why you try to do that. But it seems to me it is the only way to go, particularly for traditional people. That comfort level goes up considerably if they know there is a spiritual attachment to healing.

Mr. Rolin.

Mr. ROLIN. Senator, I have just one more comment regarding the FMAP. I noticed in the most recent Senate prescription bill that Native Hawaiian providers were included. However, our providers were left out. Certainly that is a concern we have as well. We wanted to share that with you.

The CHAIRMAN. Thank you for bringing that to my attention. I did not know that. I will make sure that we look into that and find out why.

Mr. ROLIN. Thank you.

The CHAIRMAN. I have no further questions that I will ask today. I will put some in writing to you. We have many members who are not here today. They will be submitting questions in writing, too. We would appreciate your getting those back to us.

Without objection, so ordered.

We will keep the hearing open for 2 weeks for any additional testimony or letters from anyone in the audience or from our panelists.

I thank you for appearing today.

This committee is adjourned.

[Whereupon, at 11:17 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND OF OJIBWE

Chairman Campbell, Vice Chairman Inouye and distinguished members of the Senate Committee on Indian Affairs, my name is Melanie Benjamin and I am the chief executive of the Mille Lacs Band of Ojibwe. The Mille Lacs Band is a federally recognized tribe of 3,570 members located in East Central Minnesota. We operate three clinics in three Mille Lacs Band districts on our reservation and serve a user population of several thousand.

Three topics will be discussed as they relate to Medicaid and Medicare under Title IV of the Indian Health Care Improvement Act: Sovereignty, the Federal trust responsibility and the health disparities that exist between Indians and the rest of the American population. The access to health services under title IV have a direct connection to the health disparities in Indian country and must be addressed by the Congress. Following the general discussion of the three topics under Medicaid and Medicare will be the Mille Lacs Band recommendation of the establishment of a Tribal Leaders Group and Tribal Technical Advisory Group specific to the Centers for Medicare and Medicaid Services and their work with the Indian Health Service [IHS]. The statement concludes with one final issue of concern to the Mille Lacs Band: the Department of Health and Human Services' "One" HHS Initiative.

When the Indian Health Care Improvement Act was first enacted in 1976, Congress recognized its trust responsibility toward the tribes to provide adequate health care. Throughout the subsequent amendments and reauthorizations of the Act, one of the major underlying policies has been to provide tribes access to other Federal health care sources like Medicare and Medicaid programs. These programs have unlimited funding, as opposed to Indian Health Service programs that have funding limits each year. The intent was and is to improve our health status through that access. Since then Medicare and Medicaid reimbursements to tribes, including the Mille Lacs Band, have become a significant source of revenue for our health care programs and operations.

Over the last 15 years, the Mille Lacs Band of Ojibwe has actively participated in the formulation of Tribal Self-Governance policy. We take pride in being one of the first ten Self-Governance tribes. We participated in the original demonstration project and the 1 writing of the permanent Acts for BIA and IHS Self-Governance. The Mille Lacs Band has also been on the rulemaking committees for the implementation of Self-Governance laws. Presently, the Mille Lacs Band of Ojibwe is an active member with the Tribal Self-Governance Advisory Committee that advises Federal agencies on Indian policy matters affecting the Self-Governance tribes.

The Mille Lacs Band has supported and advocated for Self-Governance laws because our philosophy is that we should be free to govern ourselves and develop our own policies in the administration of our tribal programs. To us, this is an important exercise of sovereignty. In that exercise of sovereignty, we should not be entangled by a Federal or State bureaucracy.

There are three principles that the Mille Lacs Band of Ojibwe considers when analyzing Federal programs. First, we assert that our primary relationship is with the Federal Government. This tribal-Federal relationship has been established through treaties with the United States, Executive orders, Federal statutes and numerous court decisions recognizing the same. Second, we retain all sovereignty not expressly taken away, and therefore we should have the ability to control funds reserved for us under Federal law. Third, we should have equal access to the same funding avenues as States. This third principle raises the fundamental flaw of the Medicaid and Medicare programs.

It is the Band's understanding that the design of the Medicaid and Medicare programs is a Federal—State collaboration. The problem is that tribes do not fit into the picture at all and this design flaw makes it very difficult to meet the criteria for receiving reimbursements. An example is that counties receive an administrative match from the state for their administrative costs while tribes cannot. According to the Mille Lacs Band of Ojibwe Commissioner of Health and Human Services, our inability to recover the administrative match demonstrates that tribes do not have equal access to Medicaid and Medicare reimbursements. The reason is that States determine how their block grants will be distributed under their own guidelines. As a result, the Mille Lacs Band and many other tribes lose out on potential and critical avenues of funding we desperately need because Federal funding through the Indian health service. Others on this panel have addressed this and other legal barriers more specifically, but from a tribal leader perspective it is clear that states and managed care systems have predominance over tribes under Medicaid and Medicare.

Clearly, the establishment of the Medicaid and Medicare entitlement programs happened at a time in history when the Congress did not focus on tribal sovereignty. Presently tribes are treated as governments in Federal legislation and tribal sovereignty is recognized. Indian people are provided direct access to Federal programs and funding. The Mille Lacs Band of Ojibwe receives direct funding through our Self-Governance Indian Health Service and Bureau of Indian Affairs Annual Funding Agreements. But when it comes to Medicaid and Medicare programs, it is a different situation. It is time to change the Medicaid and Medicare provisions under Title IV of the Indian Health Care Improvement Act to reflect the new enlightened view of tribal sovereignty and provide tribes more access to health care services as the Act was originally intended.

Through our treaties, Federal statutes, Executive orders and court decisions, a Federal trust responsibility has been established and recognized over the course of dealings with tribes. The Mille Lacs Band of Ojibwe signed several treaties with the United States, and the provision of proper health care became an expectation of the Band and an obligation of the Federal Government. In addition, the Snyder Act of 1921, the Transfer Act of 1954, the Self-Determination Act of 1975, the Indian Health Care Improvement Act of 1976, as well as the enactment of the IHS Self-Governance Act, all evidence the trust obligations that flow to the tribes from the Federal Government for the provision of health care.

In spite of the clear legal duty created by these Federal statutes, the Federal obligation to provide adequate health care to tribes has never been properly funded. Historically, this insufficient funding has interfered with our ability to provide comprehensive health care to Mille Lacs Band members. According to IRS estimates, the Mille Lacs Band and all other tribes in the Bemidji are funded at approximately 30 percent of need. This means more than two-thirds of our need is not being met and explains why the status of Indian health on the Mille Lacs Band Reservation and almost all other tribal reservations is so poor. We are told that the Federal Government spends nearly twice as much for a prisoner's health care than it does for Indians. This fact is an example of why our health status is at the bottom of every disease category.

It seems ironic that Indian health care through the IHS is not an entitlement for Indian people when tribes essentially pre-paid for our health care by ceding millions of acres of land to the Federal Government. It seems even more ironic that tribes have problems accessing the Federal entitlement programs like Medicaid and Medicare which were designed for all state citizens. This funding disparity becomes a matter of fairness and equity because Indian people are also citizens of the States in which we reside. It is only logical that we should have the same access to the same services as do other non-Indian citizens.

Given that we have been historically under funded for our health care needs and that tribes likely will not receive funding for the level of need in the next appropriations cycle, the Federal trust responsibility needs to be taken seriously and changes made to allow tribes full participation in the existing entitlement programs of Medicaid and Medicare. It is fair and it is right.

It has been more than 25 years ago since the Indian Health Care Improvement Act was enacted. The primary purpose of the legislation was to improve the health status of Indians to a level comparable with the general U.S. population. While strides have certainly been made in the delivery of Indian health care in that time, there continue to be health disparities in Indian country that are recited time and time again. The numbers change slightly, but one constant is that Indians rank highest in nearly every category of disease incidence than the general American population. It is plain and simple that Indian health status is not improving and something must be done.

On the Mille Lacs Band Reservation, diabetes is a very serious problem. There is not one family without diabetes among one of their family members. For many of our Band members, it is not a matter of if they get the disease, but when. Band members are losing their vision due to glaucoma complications, they are losing their limbs because of circulatory problems and many are close to requiring kidney dialysis treatments. This chronic disease affects our members' quality of life and it affects the lives of their family members.

More alarming is that diabetes and other long-term chronic health conditions are now occurring in our children and our youth. We have serious concerns for their long-term health and longevity. Our children and youth are our future and we must aggressively confront these health problems to preserve our tribal communities. There are no answers but it is clear that adequate and comprehensive Indian health care is a critical part of the solution.

The ability to provide comprehensive health care on our reservations is paramount because frequently our members will use only our tribal health facilities. The Mille Lacs Band is located in a rural area and other health care facilities are long distances. Our three clinics attempt to provide the health care our members need, but resources are quickly used and we make every effort to access outside funding through Medicaid and Medicare reimbursements within the limitations of existing law. More often than not, our efforts cannot meet our needs. We are fighting to protect the lives and health of our members on our reservations and in our communities. If Congress makes the necessary changes to Title IV of the Indian Health Care Improvement Act and provides more access to Federal health care services and funds, it will at least give us another weapon in this war on health disparities.

Under Executive Order Number 113175, the Tribal Consultation Policy, the Indian Health Service frequently solicits tribal input on health care matters that affect Indian country. The same cannot be said for other agencies within the Federal Department of Health and Human Services. Two examples that demonstrate the lack of tribal consultation are the proposed Medicaid and Medicare Reform that will affect tribal health care programs throughout Indian country.

The Department of Health and Human Services and the Mille Lacs Band of Ojibwe, along with the other federally recognized tribes throughout the United States, share the common goal of providing accessible and culturally-appropriate health care that we believe is best achieved by working together at the earliest stages of policy development and certainly prior to implementation. The Mille Lacs Band of Ojibwe endorses and supports the Secretarial appointment of a Tribal Leaders Group [TLG] that would provide policy guidance throughout the Department of Health and Human Services. The Mille Lacs Band also endorses and supports the Tribal Technical Advisory Group [TTAG] that would provide technical expertise on complicated Indian policy matters and issues specifically to the Centers for Medicare and Medicaid Services.

The Tribal Leaders Group has been sanctioned by the National Indian Health Board, the National Congress of American Indians and the Tribal Self-Governance Advisory Committee, and would be comprised of tribal leadership from each of the Indian Health Service areas. These three organizations are recognized by the Federal Government and the agencies that handle Indian affairs, but on many occasions Indian policy is overlooked by lawmakers and policymakers during the process of policy development. The Tribal Leaders Group would provide important policy recommendations to the Department of Health and Human Services on proposed initiatives that affect health care delivery throughout Indian Country, which in turn furthers the government-to-government relationship that fulfills the objectives of the tribal consultation policy.

On a more specific level, the Tribal Technical Advisory Group [TTAG] would provide the technical expertise and knowledge to the Centers for Medicare and Medicaid Services that is required when dealing with complex issues like Medicaid and Medicare Reform. The TTAG is also sanctioned by the National Indian Health Board, the National Congress of American Indians and the Tribal Self-Governance Advisory Committee. The Centers for Medicare and Medicaid Services has drafted a charter for the TTAG that provides representation from the three national Indian

organizations identified above; however, the Mille Lacs Band and the TTAG believe that the Group should also require the participation of at least three technical advisers that are familiar with health care financing and administration and how proposed changes will affect Indian country.

Through the Secretarial appointment of the Tribal Leaders Group and the Tribal Technical Advisory Group, tribal involvement from the earliest stages of policy development will ensure that Indian issues will be adequately addressed. Involvement and consultation also furthers the government-to-government relationship that the Mille Lacs Band of Ojibwe believes is part of the Federal trust responsibility to tribes.

The Mille Lacs Band of Ojibwe has a number of concerns with the Secretary of the Department of Health and Human Services' One HHS Initiative. First, the Initiative has not involved tribal consultation and that lack of consultation undermines the government-to-government relationship that tribes enjoy with the Federal Government. One of the underlying policies of Executive Order Number 13175 was and is to involve tribes at the policymaking level and work with decisionmakers to enhance the government-to-government relationship. The Mille Lacs Band of Ojibwe and other tribes want to be involved and consulted on health and human service policy matters that affect Indian country because we know best what our tribal communities need and can provide that knowledge to HHS officials.

Second, tribes' unique status as sovereign governments who are federally-recognized political entities is overlooked by the One HHS initiative. As a federally-recognized tribe, the Mille Lacs Band of Ojibwe is a sovereign government that has a government-to-government relationship with the Federal Government and its agencies. Our Self-Governance compacts are an expression of that relationship. As political entities recognized by the Federal Government, the Mille Lacs Band and other tribes cannot be treated as simply another racial minority group. The U.S. Constitution, our Treaties, Presidential Executive orders, and Federal statutes and court decisions all affirm our political status as sovereign governments that are distinctly separate from all other racial and minority groups. By engaging in tribal consultation, Federal agencies will support tribes' government-to-government relationship expressed in the above mentioned instruments.

Third, implementation of the One HHS Initiative is a departmental reorganization that fails to recognize the Indian Health Services' unique responsibility to Indian tribes. The restructuring of the HHS does not acknowledge the unique relationship between the Indian Health Service and the federally-recognized tribes. By incorporating Indian health care into public health and minority health programs, the Indian Health Service may lose its ability to provide direct medical services to tribes and eventually may see the loss of programs designed specifically for tribes. Inherent in the restructuring is an alteration of the Federal trust responsibility. Indian Health Service exists to fulfill the Federal trust responsibility of providing health care to tribes across the United States and attempting to improve the health status in Indian country. Removing that trust responsibility runs counter to the very purpose of the Indian Health Care Improvement Act.

The Mille Lacs Band of Ojibwe recognizes that improvements have been made in the delivery of health and human services since the enactment of the Indian Health Care Improvement Act in 1976. However, we still have significant health disparities in our communities that have not seen improvement. This tells us there must be greater efforts to address Indian health disparities. Those efforts must involve tribal consultation and coordinated discussions for any result to be obtained. It is not too late to engage tribes and begin working together to move forward and improve Indian health disparities.

Miigwech.

PREPARED STATEMENT OF BUFORD ROLIN, VICE CHAIRMAN, POARCH CREEK OF INDIANS

Chairman Campbell, Vice Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Buford Rolin, member at large of the National Indian Health Board. I am an elected official of the Poarch Creek Band of Indians, serving as vice chairman. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on the Reauthorization of the Indian Health Care Improvement Act.

The NIHB serves nearly all federally recognized American Indian and Alaska Native (AI/AN) tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. We strive to advance the level of health care and the adequacy of funding for health services that are operated by

the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the 12 areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

I would first like to commend the witnesses that testified before me this morning, Mim Dixon and Myra Munson, for their tireless work and expertise on American Indian and Alaska Native issues related to Medicare, Medicaid and the Children's Health Insurance Program. I am also much honored to testify this morning alongside Chief Executive Melanie Benjamin of the Mille Lacs Band of Ojibwe.

Given the two previous hearings the committee has held on the Indian Health Care Improvement Act during the 108th Congress, I'm going to be brief this morning. I realize the members are quite aware of the need and purpose of the reauthorization; therefore I would like to focus on the efforts of tribal leaders to craft legislation that addresses previous concerns raised by the Administration and responds to the current political realities facing Congress.

The National Steering Committee [NSC] was formed by the Indian Health Service in 1999 to develop and submit recommendations for changes to the Indian Health Care Improvement Act. The NSC is comprised of elected tribal representatives throughout Indian country, and also includes urban health program representation. The NSC is currently cochaired by Julia Davis-Wheeler, NIHB Chair, and Rachel Joseph of the Lone Pine Paiute Shoshone Tribe.

Over the last several years, the NSC has worked closely with Indian country, the Administration, Congress, and the Indian Health Service to develop amendments to the Indian Health Care Improvement Act. Indian country has proceeded through this process in a spirit of cooperation and negotiation and the language has gone through several changes.

At the request of Tribal leaders, the Centers for Medicare and Medicaid Services [CMS] established the Tribal Technical Advisory Group (TTAG) to advise CMS on Medicare, Medicaid, and Children's Health Insurance (CHIP) policy issues related to American Indians and Alaska Natives. The TTAG was formed in 2001 and consists of Tribal leaders, Area Indian Health Boards, and designated national Tribal organizations, including the National Indian Health Board. The activities of the TTAG are coordinated primarily through the Intergovernmental and Tribal Affairs Office within CMS.

The TTAG has forwarded several recommendations to Congress and CMS regarding recommended changes to the reimbursement methodologies in place for the Indian Health Service, Tribal health programs, and Urban Indian programs. The TTAG is adamant in its position that any reform or changes in the Medicare, Medicaid, or CHIP programs must allow for Tribal allocation or other direct funding mechanisms that authorize Indian health programs access to Centers for Medicare & Medicaid Services (CMS) program funding.

The TTAG has worked closely with the National Steering Committee to develop the changes to Title IV of the Indian Health Care Improvement Act that are reflected in H.R. 2440, which are the most recent NSC recommendations.

As the committee is well aware, funding for the Indian Health Service lags far behind other segments of the population and has failed to keep pace with population increases and inflation. Current Indian Health Service funding is so inadequate that less than 60 percent of the health care needs of American Indians and Alaska Natives are being met. In order to address the need for additional health care resources, Title IV of the Indian Health Care Improvement Act addresses access to Medicare, Medicaid and other third party reimbursements. It is one of the most important provisions of the Indian Health Care Improvement Act as it makes IHS hospitals eligible for Medicare reimbursements, and also makes IHS facilities eligible for Medicaid reimbursements. Title IV makes it possible for Medicare and Medicaid eligible American Indians and Alaska Natives to utilize these benefits.

Since the passage of the Health Care Improvement Act in 1976, Medicare and Medicaid payments have become vital sources of revenue for basic tribal hospital and clinic operations. In fiscal year 2002 alone, IHS and tribally operated hospitals and clinics collected \$460 million for services provided to Indian people enrolled in these programs. This amount enhances the resources available for the IHS hospitals and health clinics budget by nearly 30 percent.

In order to further improve the ability of Indian Country health providers to access third party resources, the NSC developed several changes to Title IV that were included in S. 212 introduced during the 107th Congress. When asked to respond to the language contained in S. 212, several concerns were raised by Health and Human Services Secretary Tommy G. Thompson regarding the proposed changes to title IV. The concerns were primarily related to costs. I would like to note that S.

556 introduced during this Congress is identical to S. 212 and therefore many of the concerns raised in regards to S. 212 remain.

In response to those concerns, the National Steering Committee revised their recommendations for the reauthorization and those changes are reflected in H.R. 2440, which was introduced on June 11, 2003. I think it was quite helpful to hold the joint Senate Committee on Indian Affairs and House Resources Committee hearing on the IHCA last week as it illustrates the efforts of both houses to pass a bill this session. Although the bill was introduced in the House, it was developed with input and involvement from both Senate and House members and staff.

H.R. 2440 reflects several changes made to the original tribal proposal prepared in 1999 by the National Steering Committee (NSC). The legislation includes revisions to the 1999 proposal in response to the Secretary Thompson's concerns. Some of the major changes of the revised Tribal recommendations made in H.R. 2440 that respond to the Administration's concerns about S. 212.

Qualified Indian Health Program [QIHP]. This provision has been removed. The NSC designed QIHP as a new provider type through which Indian health programs and urban Indian health programs could more fully exercise their statutory authority to receive payments under Medicare, Medicaid and SCHIP. Secretary Thompson expressed concern that QIHP was complex and would be administratively burdensome. Tribal leaders acknowledged that the CBO score of this provision—in excess of \$3 billion over 10 years—could be a barrier to Congressional acceptance of QIHP and therefore removed it.

In place of the QIHP proposal, Tribal leaders seek a comprehensive study by the Department of Health and Human Services [DHHS] of reimbursement methodologies of Medicare and Medicaid for the Indian Health Service [IHS], Tribal health programs, and health programs of urban Indian organizations. The new provision found in H.R. 2440 directs the Secretary to perform such a study and report the findings to Congress. The Secretary is to examine whether payment amounts under current methodologies are sufficient to assure access to care and whether these methodologies should be revised consistent with those applicable to the “most favored” providers under the Social Security Act. The current “all-inclusive” rate system through which IHS and tribal hospitals and some clinics now receive Medicare and Medicaid reimbursements would remain in place until the Secretary's recommendations are reported to Congress and Congress decides whether to make any changes.

Extension of 100 percent Federal Medical Assistance Percentage [FMAP]. Tribal leaders also agreed to delete a provision that would have extended the 100 percent FMAP to services provided to Medicaid eligible Indians referred by IHS or tribal programs to outside providers, such as referrals made through the contract health services program. Under current interpretation of the Centers for Medicare and Medicaid Services [CMS], the 100 percent FMAP is made available to States only for reimbursements for services provided directly in an IHS or tribal facility, even though the only reason the patient required care outside the IHS or tribal facility was that the facility could not directly provide the service and had to rely on an outside provider.

While State governments are very supportive of the 100 percent FMAP expansion, DHHS objected that its cost was too high—more than \$2 billion over 10 years—and that its financial benefits would flow only to the States, not to Indian health programs and their Indian beneficiaries. While the NSC disagrees with the Department's interpretation of the statute and their conclusions about the effect of the proposed amendment, we agreed to delete the provision from the IHCA.

Waiver of Medicare Late Enrollment Penalty. The 1999 tribal proposal—and S. 212 and S. 556—sought to waive the premium penalty for any Medicare-eligible Indian who did not timely enroll in Medicare Part B because of a number of barriers. The DHHS strongly objected to this provision as it would treat Indians differently than other Medicare-eligible persons who do not timely enroll. The DHHS asserts that the penalty is needed to encourage eligible persons to enroll and begin paying Part B premiums when they first become eligible, rather than waiting until they become ill and need to use their Medicare coverage. Tribal leaders also agreed, reluctantly, to delete this provision.

Regulations. Secretary Thompson objected to the tribal leaders' call for all regulations—including Social Security Act regulations affecting Indian health providers—to be prepared through Negotiated Rulemaking with tribal representatives. He asserted that the large number and complexity of Social Security Act regulations makes negotiated rulemaking unfeasible. In response to this concern, tribal leaders eliminated Social Security Act changes from the bill's negotiated rulemaking provision.

We believe the changes to the original tribal proposal submitted in 1999 significantly reduce the bill's Federal budget impact. S. 212 [identical to S. 556] was scored in 2001 as having a Federal budget impact of \$6.9 billion over 10 years. Deletion of the QIHP and the 100 percent FMAP provisions together reduce the bill's score by about 70 percent. We ask that the committee submit a request to the Congressional Budget Office to either score S. 556 without the above mentioned provisions, or provide a fiscal budget impact on H.R. 2440.

Conclusion. On behalf of the National Indian Health Board, I would like to thank the committee for its consideration of my testimony and for your diligence in making the health of American Indian and Alaska Native people a high priority of the 108th Congress. I have been involved with the National Steering Committee since its inception in 1999 and have seen the hard work and compromises that the tribal leaders have made. Tribal leaders have come to the table to work out the more contentious provisions and we urge the committee to act swiftly on this important piece of legislation. Further, we request that any concerns regarding this legislation are raised in a timely manner so that passage of this bill during this session is not jeopardized.

BUFORD ROLIN, MEMBER AT LARGE, NATIONAL INDIAN HEALTH BOARD, RESPONSES
TO QUESTIONS

On behalf of the National Indian Health Board [NIHB], a non-profit organization established in 1972 to serve nearly 558 federally recognized tribal governments in advocating for the improvement of health care delivery for American Indians and Alaska Natives, I am pleased to respond to your letter dated August 1, 2003 regarding my recent testimony on S. 556, the Indian Health Care Improvement Act Reauthorization.

No. 1. Federal Medical Assistance Program [FMAP]. There appears to be a concern that a 100-percent FMAP provision is too costly.

Question A—What is the purpose of the 100 percent FMAP and what are the cost estimates used to determine the provision was too costly?

Response. The discussion of the 100 percent FMAP provision, section 212 of S. 556, has become quite complicated. The National Steering Committee [NSC] endorses passage of a provision of law that will clarify the intent of Congress and require full implementation of what we, and many states, believe is existing law. We are hopeful that the 100 percent FMAP provision will compel the Centers for Medicare and Medicaid Services [CMS] to do what we think it should already do.

After the Congressional Budget Office [CBO] issued its score on the provision in S. 212, the predecessor to S. 556, and the Administration expressed its objection to the provision, the NSC reluctantly determined that the provision was likely to hinder efforts to reauthorize the Indian Health Care Improvement Act and therefore agreed to its removal from the bill in favor of free-standing legislation. Current law states: "the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1602 of Title 25)."

42 U.S.C. § 1396 (d) (b) (emphasis added.). The NSC believes that "through" encompasses all services provided directly by the Indian Health Service [IHS] and tribes and tribal organizations operating health programs under the Indian Self-Determination and Education Assistance Act [ISDEAA], as well as non-facility based services—such as home and community-based services—and services that the Indian health program would have paid for from its contract health service program, but for the patient being Medicaid eligible. CMS has generally interpreted "through" to mean "in," applying the 100 percent FMAP only for services provided in an IHS or tribal facility.

Authorization of 100 percent reimbursement for States for services provided through the IHS reflects Congressional understanding that the obligation to provide health care to American Indians and Alaska Natives is a Federal obligation deriving from the Constitution, treaties and laws and paid for by tribes with hundreds of millions of acres of land. Pragmatically, it serves to encourage States to recognize the importance of IHS and tribal providers to ensuring that Indians have access to culturally appropriate and sensitive health care. Please see the response to question B for a more thorough discussion of this latter point.

Unfortunately, the NSC is not privy to the CBO scoring methodology or to information that may have been provided to CBO by CMS. We do believe it is highly probable that the score is inflated substantially. Many States have interpreted the

current law to permit them to claim exactly what is described in § 212 of S. 556. Accordingly, they have been claiming, and until recently, often been being reimbursed, at that level. Thus, the expenditures are not new, but part of the current budget.

Second, we believe it possible that the score includes an estimate of the cost of all services to Indians by non-IHS providers whether there was a referral from the IHS or tribal health program or not. This would significantly inflate the score. The intent of the NSC is only that services provided based on such a referral be included. By limiting it in this way, the continuity of care for Indian patients and the integrity of the Indian health system are retained.

The score was so high that it also makes us wonder if CBO was relying on census numbers for estimating the number of Indians instead of the number of active users in the Indian health system. What is clear to us is that American Indians and Alaska Natives are not receiving the benefit of services in amounts anywhere equivalent to the CBO estimates and that the Indian health system continues to be dramatically underfunded to carry out its mission. Both should be remedied.

Question B—If FMAP is not enacted, is there a chance that some States may not extend services to Indians unless the 100-percent FMAP applies?

Response. The relationship between States and tribes varies dramatically from State to State, administration to administration, issue to issue. It ranges from enmity, to distrust, to indifference with occasional shining lights of cooperation. The hostilities arise typically from historical and present conflicts over control of resources—land, minerals, water, tax base, to name a few. The indifference arises from a view that since there is a direct Federal/tribal government-to-government relationship, the State has no role. This is reinforced by the human tendency to set priorities based on the “out-of-sight out-of-mind” principle under which rural and remote communities suffer, including Indian communities. Increased reimbursement for Medicaid expenditures won’t cure all of this, but it would be a substantial help.

After the execution of the 1996 Memorandum of Agreement between the Health Care Financing Administration [HCFA] [now CMS] and IHS, many States demonstrated a significantly higher willingness to work with IHS and tribes to include them in their Medicaid programs as providers and as programs able to assist Medicaid-eligible Indians to exercise their right to participate in the Medicaid program. This did not happen overnight and it continues to require diligence and outreach by IHS and tribes, but gradually it did happen.

We hesitate to say that states will roll back their cooperation if the narrower interpretations by CMS of their right of recovery is not overcome, but in a time when all states are experiencing financial pressures, particularly centered on their Medicaid programs, it is a high risk. It is a risk we do not believe we should have to take.

No. 2. 1996 MOA between IHS and DHHS: The 1996 Memorandum of Agreement between IHS and DHHS established a 100-percent FMAP which applies to certain services provided by IHS and Tribal “638” programs at their facilities.

Question—Does the MOA apply to tribes who provide programs that are not contracted such as long-term care and, if not, should it?

Response. In our view the MOA did not change anything substantive about the coverage. It makes tribal health facilities, health facilities of the IHS, as if there were a lease between IHS and the tribe, in order to avoid the wasteful exercise of IHS actually having to enter into such leases. Whether the MCA extends to long-term care, is really a question about whether the IHS and tribes should offer long-term care health services, and whether tribes have the right to do so, even if not directly funded by IHS to do so. We believe the answer to all these questions is “yes.” Tragically, long-term care wasn’t a priority of the IHS because Indians did not live long enough to require it. Tragically, long-term care couldn’t be a priority because IHS was so short-funded it could not meet acute care demand, let alone expand to long-term care. Tragically, Indians who were reluctant to leave their families and communities to receive long-term care simply had to forego that option because there were few, if any, nursing homes on or near reservations and predominantly Indian communities.

Thankfully, life expectancy is increasing and long-term care doesn’t only have to mean nursing home care, although it is still an important component. Indian tribes and tribal organizations are exercising their right to assume responsibility for carrying out programs of the IHS under both Title I (self-determination) and Title V (self-governance) of the ISDEAA and achieving efficiencies and program improvements only imagined by the IHS under which they can exercise authority to set priorities locally and redesign their programs accordingly. Some tribes have even developed the capability of contributing tribal resources to the mix of funding for health services and this has meant expansion of services, including long-term care. When this

occurs, the MOA absolutely should cover tribal long-term care. In our view, the better question would be why it shouldn't cover long-term care.

Most health care expenditures come at the end of life—some of that expense is due to long-term care. Why should Federal financial participation in delivering health services to American Indians and Alaska Natives end just at the point the expense becomes greatest?

No. 3. States Denying Care to Indians. Federal health care to Indians arises from the special relationship with and obligations of the United States. But, as U.S. citizens, Indians also have equal access to other public health programs available to all other U.S. citizens.

Question—Is the National Steering Committee aware of cases where States have refused public health insurance coverage for eligible Indians because of the belief that health care is a “Federal responsibility”?

Response. The National Steering Committee is not aware of a consistent pattern of such refusals however, tribal leaders are aware of individual cases where this has occurred at the application level. Despite the well established Federal responsibility to provide health services to American Indians and Alaska Natives, tribal members are often discriminated against and are denied the opportunity to even apply for other public health programs based on the “Indians receive free health care,” misconception. The result is that tribal members often avoid utilizing such resources in order to avoid such discrimination and do not utilize those resources that are available to them.

Another barrier that exists for tribal members in accessing services outside of the HIS, Tribal, and Urban (I/T/U) system is the eligibility application process. The application process is quite lengthy and arduous, which discourages participation. Tribal leaders are aware of these problems and are taking steps to address them, such as working with States to increase participation.

Statement by Mim Dixon¹
to
Senate Committee on Indian Affairs
Hearing on Reauthorization of the
Indian Health Care Improvement Act

July 23, 2003

Senators, Tribal Leaders, Honored Guests. I thank you for the invitation to offer my observations about Title IV of the Indian Health Care Improvement Act currently proposed for reauthorization.

It has been my privilege to serve tribes as a health care administrator, researcher and policy analyst for more than 30 years. I have seen many changes during this time, including the emergence of tribally-operated health care delivery systems. At the same time, the private and public insurance programs in our country have changed from predominantly fee-for-service to managed care.

There is a lot of talk recently about "modernizing Medicare." In a way, the proposed Title IV of the Indian Health Care Improvement Act and the proposed amendments to Medicare and Medicaid could be considered "modernizing Indian health care." As we know, this is not an appropriations bill and it will not provide the funding to bring programs and facilities up to the standards that would truly modernize Indian health care. It is interesting to me that the Federal Employee Benefit Package has been cited by the Bush Administration as a benchmark for Medicaid and Medicare reform. As you know, Indian Health Service has conducted a comparison of Indian health funding and the Federal Employee Benefit Package which shows that Congressional funding for IHS is only 52 percent of the level of need.² While S. 556 includes attempts in Title IV to address the huge funding gap that has resulted in health disparities among American Indians and Alaska Natives, most of those provisions have been stripped out of H.R.2440, thereby reducing the cost of Title IV by 70 percent.

So, when I talk about "modernizing Indian health care," I am not talking about the delivery of services. Rather, I am talking about modernizing the legal and regulatory framework that allows the Indian health programs to bill Medicaid, SCHIP, Medicare and private insurance and to be paid for the covered services that are provided to their mutual beneficiaries. Title IV and the technical amendments to the Social Security Act codify some administrative decisions that are already in effect and make changes in the law to allow the IHS and tribes to operate in a manner that creates a rational interface with Third Party Payers.

¹ Mim Dixon, Ph.D., is a consultant with Mim Dixon & Associates, 1618 Spruce Street, Boulder, CO 80302.

² FY 2003 IHCIF – Area Summary. Posted on the website www.ihs.gov. March 28, 2003.

To better understand why I call Title IV "modernizing Indian health care," consider some of the changes that have happened in the past 25 years.

Many of you have been involved in Indian health policy longer than I have. And you will remember that the Indian health system was not permitted to bill Medicaid or Medicare until 1976 when the first Indian Health Care Improvement Act amended the Social Security Act, to create section 1880 (Medicare) and section 1911 (Medicaid). It took a long time for the Indian Health Service and tribes to figure out how to bill third parties.

This effort was frustrated by the development of IHS computer software for patient care management that did not even have a billing component. The persistent underfunding of the Indian Health Service has resulted in prioritizing services, such that the acquisition of computer software for billing purposes has necessarily been a low priority. So, third party revenues grew very slowly at first.

The growth in Medicaid and Medicare collections in Indian health facilities has paralleled the growth in tribal contracting and compacting. A survey of tribes in 1998 found that one of the first things tribes did when they starting operating their own health care delivery systems was to develop billing systems to increase their revenues.³ Between 1993 and 1997, the third party income to the IHS increased by 80 percent.⁴ A significant factor in the growth of Medicaid income was the 1996 agreement between the IHS and the Health Care Financing Administration (now called Centers for Medicaid and Medicare Services) that changed the payment policies for tribally-owned and operated facilities to enable them to receive Medicaid payments at the IHS "all-inclusive" rate, and provided a 100 percent Federal Medicaid Assistance Percentage (FMAP) for services provided in those facilities.⁵

Just about the time that the Indian health facilities figured out how to collect Medicaid and Medicare for beneficiaries who used Indian health services, the whole system changed. Medicaid began to emulate the changes in the private insurance industry, shifting to managed care. In most states, tribes were not included in the planning for changes in the Medicaid program, or the development of the SCHIP programs.⁶ It was only six years ago, in 1997, that the Kaiser Family Foundation funded NIHIB to do a series of case studies of

³ Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith CM. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Vol 4.* Denver, CO: National Indian Health Board. 1998.

⁴ Mather D. Chapter 4: IHS Financial Trends during Self-governance (Title III) Compacting, FY 93 to F 97. In: Dixon M, Shelton BL, Roubideaux Y, Mather D, Smith CM. *Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management. Vol 4.* Denver, CO: National Indian Health Board. 1998.

⁵ Indian Health Service and the Health Care Financing Administration. Memorandum of Agreement (MOA) signed December 19, 1996.

⁶ Dixon M. *Indian Health in Nine State Medicaid Managed Care Programs.* Denver, CO: National Indian Health Board. 1998b.

managed care in Indian communities.⁷ At that time, tribes and the IHS were trying to figure out what managed care was and how they fit into this new system of organizing and paying for health care.

It is difficult for Indian health care to interface with the Medicaid, SCHIP and Medicare of today. Indian health programs are unique in many ways, including tribal sovereignty, the federal trust responsibility and the government-to-government relationship that has existed since before the U.S. Constitution was written and has a long tradition in federal law.⁸ Indian health programs are also unique because they embody certain legally-established attributes that are expressly prohibited in other government-funded health programs, such as Indian preference in hiring and restricting services to enrolled members of federally-recognized tribes. Perhaps most unique is a health care delivery system so underfunded that it would not be able to stay in business in the private sector, that rations health care according to a priority system, and that does not include the cost of facilities in its rate structure for billing for services.

All of these attributes make it impossible for many Indian health facilities and programs to meet the usual requirements to serve as contracted providers for managed care programs under Medicaid, SCHIP and Medicare programs. In addition, many Indian health facilities cannot meet requirements such as having physicians on-call 24-hours per day, and having modern facilities that meet safety and accessibility codes. Furthermore, Indian health programs usually cannot take the risk involved in managed care contracts.

Despite all the short-comings of the Indian health programs, American Indian and Alaska Native people usually prefer to use them.⁹ These programs are more accessible for AI/AN communities and offer care that is more responsive to cultural needs. Furthermore, these programs provide much needed employment for AI/AN communities. AI/AN beneficiaries who are enrolled in managed care plans under Medicaid or SCHIP will go off plan to seek care at their Indian health care facility. It is essential that they have that unrestricted choice and that the Indian health facility can bill and be paid for the services they provide. These policies are included in the IHCA (section 406 of S. 556, Section 403 of H.R. 2440).

⁷ Dixon M. *Managed Care in American Indian and Alaska Native Communities*. Washington, D.C.: American Public Health Association. 1998b.

⁸ Shelton, Brett Lee. Chapter 1: Legal and Historical Basis of Indian Health Care in *Public Health Policy for American Indians and Alaska Natives in the 21st Century*, Mim Dixon and Yvette Roubideaux (eds). Washington, DC: American Public Health Association. 2000.

⁹ Dixon M, Lasky PS, Iron PE, Marquez C. Factors Affecting Native American Consumer Choice of Health Care Provider Organizations. In: *A Forum on the Implication of Changes in the Health Care Environment for Native American Health*. Washington, DC: The Henry J. Kaiser Family Foundation. 1997.

In 1998, the National Indian Health Board conducted a study of managed care in nine state Medicaid programs.¹⁰ NIHB held a national meeting where recommendations were adopted by the tribes. These recommendations attempted to respond to the growing managed care environment to assure that American Indian and Alaska Native people would have access to culturally competent care through their tribal, urban and IHS clinics. In 2001 there was a follow-up study with ten state Medicaid programs.¹¹ It showed that the CMS had implemented some of the recommendations from the previous study. Many of the recommendations from both studies are included in the Senate and House bills.

Despite the increasing reliance of Indian health programs on Medicaid and other third party collections, many American Indians who are eligible for Medicaid and SCHIP are not enrolled in the program.¹² The proposed IHClA reauthorization bills attempt to remedy this situation by authorizing funding for tribes for outreach services, including education regarding eligibility and benefits, translation services, and transportation to offices of eligibility workers (section 404 of S. 556, and section 402 of H.R. 2440).

The bills would also eliminate financial barriers to enrollment, such as premiums, deductibles and co-pays (section 419 of S. 556, and Section 412 of H.R. 2440). These provisions are extremely important because most AI/AN have no incentive to pay for additional health coverage when the Indian health services are provided to them with no out-of-pocket payments. The prohibition against the states charging AI/AN premiums and co-pays is already in place administrative for SCHIP, but it is important to codify this and make it consistent across Medicaid programs as well. It is troubling that the Medicare program deducts 20 percent from its already low payments to Indian health programs for the amount that the Medicare beneficiary is supposed to pay, despite the fact that Indian health programs are prohibited from collecting this amount from consumers. The proposed IHClA does not address this problem for Medicare, but it does protect against this practice in Medicaid and SCHIP.

In the past five years, tribes have begun to work more closely with states and with the federal government to resolve issues related to Medicaid, SCHIP and Medicare. Putting these provisions into law will clarify areas of ambiguity, resolve problems that can only be resolved through changes in the law. It will

¹⁰ Dixon M. *Indian Health in Nine State Medicaid Managed Care Programs*. Denver, CO: National Indian Health Board. 1998.

¹¹ Kauffman JA, Hansen P, Paternoster V. *Into the Future: Indian Health, Medicaid, Managed Care & SCHIP, a Ten State Medicaid, Managed Care and SCHIP Program Study*. National Indian Health Board. Draft Report, December 20, 2001.

¹² Rosenbaum S. *Medicaid and Indian Populations: Issues and Challenges*. In: *A Forum on the Implications of Changes in the Health Care Environment for Native American Health Care*. Washington, DC: The Henry J. Kaiser Family Foundation. 1997.

"modernize" the law regarding third party collections for Indian health facilities by addressing issues that didn't even exist until the past decade.

Provisions in the proposed IHCA Act also allow tribes to take advantage of some of the opportunities provided by managed care. For example, tribes, tribal organizations and urban Indian programs could use their funding from IHS to purchase managed care plans or other insurance coverage for their beneficiaries (Sec 408 of S. 556 and Sec. 405 of H.R. 2440). This may be particularly useful for small tribes that would not have enough resources to offer comprehensive health services on their own. It also may help to stimulate tribes and tribal organizations to own and operate health care plans. Furthermore, the bills would protect tribal sovereignty while promoting quality care, by eliminating any requirements that tribal health programs be licensed under state or local law if they meet accreditation standards recognized by the Secretary of DHHS (Section 411 of S. 556, section 408 of H.R. 2440). The measures would also require states to allow Indian health providers to serve as case managers for AI/AN Medicaid beneficiaries (section 423 of S. 556, section 413 of H.R. 2440).

Many of the issues relating to health care financing are extremely complicated. There are a handful of technical experts working for tribes as health directors, consultants and attorneys. Tribes have recognized that there is a need for these technical experts to work closely with CMS to resolve problems as they arise. NIHB, NCAI and TSGAC have called for a Tribal Technical Advisory Group (TTAG) for CMS. They have designated individuals to serve on an interim TTAG until such time as CMS can establish a formal TTAG. Once again, there is a disconnect between the unique role of tribes and the regulatory framework for advisory committees. To operate effectively, the TTAG must be authorized in law, as proposed in section 409 of H.R.2440 (which was revised and improved after section 425 of S. 556 was drafted). The need for this TTAG is urgent. The interim TTAG has already identified 65 issues that need resolution with CMS, and the TTAG will be essential to helping CMS write regulations for the proposed Medicare reform, proposed Medicaid reform, and the new provisions in the IHCA.

In summary, Title IV and the Social Security Act amendments are needed to respond to changes that have occurred in health care delivery in our country in the past decade. Just a few years ago, there was no Medicaid managed care, there was no SCHIP, there was no Medicare Part C or D or E. The complexities of health care financing can be overwhelming. So, it is important to remember the purpose of this legislation. At the heart of the provisions in Title IV is enhancing access to care for American Indians and Alaska Natives, protecting their rights to choose their health care providers, and assuring that Indian health facilities get paid when they provide covered services to Medicaid, SCHIP and Medicare beneficiaries.

Testimony of

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Before the Senate Committee on Indian Affairs
Regarding the Reauthorization of the Indian Health Care Improvement Act
H.R. 2440 and S. 556
Title IV and Amendments to the Social Security Act
July 23, 2003

Chairman Campbell, members of the Committee, thank you for the opportunity to testify regarding the reauthorization of the Indian Health Care Improvement Act (IHCA). The last time I had the privilege of testifying before this Committee was in the late 1980s when I was serving as Commissioner of the Department of Health and Social Services for the State of Alaska. In 1990 I left that post and since have had the honor of representing tribes and tribal organizations as a member of the Sonosky, Chambers Law Firm.

Since the formation of the National Steering Committee (NSC) I have worked with its members, on behalf of the Alaska Native Health Board (ANHB) and the Alaska Native Tribal Health Consortium (ANTHC), to develop and advocate for the reauthorization of the Indian Health Care Improvement Act. Although I have worked on all parts of the bill, due to my experience with Medicaid, Medicare and other third-party recovery, I worked most closely with the members of the National Steering Committee whose task it was to examine the provisions of the Act relating to access to health services – a euphemism for provisions related to financing.

Throughout its work on the Indian Health Care Improvement Act, the National Steering Committee recognized that the IHCA addresses authorization, not appropriations. The IHCA, in other words, provides the opportunity, but not necessarily the means. Title IV and the two amendments to the Social Security Act, sections 4 and 5 of H.R. 2440 and Title II of S. 556, are the exception. They actually address mechanisms by which the Indian Health Service (IHS), tribal health programs, and urban Indian organizations can receive reimbursement for the services they provide and thereby reduce the chronic underfunding for Indian health services.

Background

In 1976 during the first authorization of the Indian Health Care Improvement Act, Congress authorized the Indian Health Service and tribal health programs operating through IHS facilities to bill Medicaid and Medicare. This was controversial then and is still. The United States owes a duty to American Indians and Alaska Natives to provide them with health care. Until 1976 that duty had been carried out, however inadequately, through direct appropriations. Since then, some part of each year's budget for the Indian Health Service and for tribal health programs has been assumed by Congress to be available from third-party revenues generated by billing Medicaid, Medicare, and other third-party insurance.

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This was not a choice embraced easily by tribes. For many, it appears as an abrogation of the duty by the United States to provide health care, or at least a step in that direction. Many American Indians and Alaska Natives resented being required to apply for Medicaid, a needs-based program equated with welfare. They found it humiliating to have to reveal private information about themselves in order to have access to services to which they had been promised access. This view is one held especially by the elders, who also fear that reliance on Medicaid will result in the loss of trust assets that would otherwise be passed down to their children.

Tribes and the Indian Health Service have worked hard to overcome these concerns. Pragmatically, there was simply no other choice. Appropriations fail even to keep up with the inflation, let alone begin to close the gap between need and the resources to respond even in part to that need. Third-party revenue simply had to become part of the mix of funding.

To begin to achieve the targets set by the Congress in its budget for the Indian Health Service, the IHS and tribal health programs were compelled to divert resources from other activities to develop billing and coding expertise and systems. As other testimony being provided to you today describes, developing the capacity to carry out this Congressional mandate has been difficult. The information system principally relied upon by IHS, and inherited by tribal health programs as they assumed responsibility under the Indian Self-Determination and Education Assistance Act, is ill-suited for billing. Efforts to develop new software for billing as an add-on or to find software that was compatible has consumed thousands of hours and millions of dollars.

Nor, has the task been made easier by the entities from whom reimbursements are due. Private insurance companies who have been obliged to reimburse IHS and tribal health programs have resisted. Although they collected premiums for the provision of insurance, the fundamental principle underlying most insurance is that it pays only when the covered individual has a personal duty to pay, but for the insurance. Since American Indians and Alaska Natives do not have such a duty when they receive care from an Indian health program, many insurers simply would not believe that the law meant what it said. Both the IHS and tribes have had to resort to litigation to overcome the resistance from private insurers. Although that litigation has been successful, skirmishes occur regularly.

Medicare and Medicaid have posed different, but equal challenges.^{1/}

Medicare. Medicare is a national health insurance program for the elderly and disabled. Individuals over 65 years of age are automatically entitled to Medicare Part A if they (or their spouse) are eligible for Social Security payments. A relatively small percentage of Indians enjoy eligibility for Medicare since many elders lacked opportunities to work at jobs that contributed to Social Security. As the life span grows for Indians and more participate in the workforce, the

1/ I am indebted in the following descriptions of Medicare and Medicaid to the work of the Kaiser Family Foundation for its remarkable work in translating complex Social Security Act programs into English and thereby making them more accessible. See MEDICARE FACT SHEET, MEDICARE AT A GLANCE, April 2003, and THE MEDICAID PROGRAM AT A GLANCE, February 2003, published by the Kaiser Family Foundation, and available, along with many other documents, at its website: www.kff.org.

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numbers of Indians who are eligible for Medicare will increase.

Medicare Part A pays for inpatient hospital and skilled nursing facility services, home health visits following a hospital or skilled nursing facility stay, and hospice. Medicare Part B is available only to those Medicare eligibles who enroll and pay a monthly premium of \$58.70 or \$740 annually in 2003. Few elders who have access to an Indian Health program enroll for this benefit since they correctly believe they should be entitled to free health care. For the poorest elders, Medicaid may pay the premiums. Medicare Part B reimburses providers for outpatient hospital services, physician services, laboratory costs, durable medical equipment, and other services. All Medicare payments are subject to deductibles, copayments, and various limitations on the amount of service for which it will pay.

Currently, IHS and tribal facilities may recover only for services provided by hospitals and skilled nursing facilities and, in the past two years, for a limited number of outpatient services reimbursed under Part B. Medicare payments for inpatient hospital services are based on diagnosis; for outpatient hospital services most providers will be required to bill according to a new and complex classification system that is part of the implementation of the outpatient prospective payment system adopted by Medicare. Other services are generally reimbursed on the basis of fee schedules or cost reporting data. The exceptions to the general rules are many, however. There are special reimbursement standards for federally qualified health centers, critical access hospitals, disproportionate share hospitals, certain cancer treatment hospitals, certain children's hospitals, and, at least for now, IHS hospitals (whether operated by IHS or a tribe.)

Reimbursements to IHS and tribal hospitals for outpatient services have been based on a per day rate sometimes referred to as the "encounter rate," "the OMB rate," or the "all-inclusive rate." It is a per day amount for all outpatient services provided on that day. It is negotiated annually between IHS and the Centers for Medicare and Medicaid Services (CMS) based on cost reports submitted by a number of IHS and tribal hospitals. (All payments are less the 20 percent copayment even though the Indian beneficiary is not obliged to pay the copayment.)

This simplified billing method has made recovery possible for facilities that have lacked the capacity to do full individual cost reports and for whom satisfying the requirements of the new outpatient prospective payment system regulations would have been virtually impossible and would have diverted millions of dollars away from other services into new information systems necessary to comply with the complexities of that system.

IHS and tribal clinics not closely connected to an IHS hospital have largely been without any Medicare reimbursement. The newly authorized recovery for Part B services helps a little, but as noted above there are a relatively small number of Indian enrollees. In addition, the recovery for professional services is very low relative to the cost of providing the services and no reimbursement for the cost associated with the facility are included. A few overcome this problem by enrolling as federally qualified health centers, but for many the cost of compliance with the cost reporting requirements, combined with the reality that actual cost is never paid,

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Medicaid. Medicaid is the principal public health insurance program for poor Americans. It is a state/federal partnership in which both contribute financially in varying amounts. Federal participation imposes certain limitations on states about who must be served, principally children and their parents living below a certain poverty level; the services that must be covered; and the practitioners who must be allowed to provide certain services. Beyond these minimums, states have great, although not unlimited, flexibility in adding additional populations to be served, services that are covered, and practitioners whose work may be compensated. States are largely responsible for setting their own reimbursement methodologies, again subject to certain constraints. Thus, there are effectively 50 nearly unique Medicaid programs.

When the IHS, tribal health programs and urban Indian organizations participate in Medicaid, they do so largely under the unique conditions imposed by each state as it develops its own program. Thus, the scope of the activity that each program may be reimbursed for and how it will be reimbursed varies dramatically from one state to another. This creates significant challenges for IHS and those tribes that operate health programs in more than one state.

In fiscal year 1997, IHS and tribally operated facilities were projected to receive \$184.3 million in Medicaid reimbursements.^{2/} This was about 10 percent of the \$1.8 billion appropriated for IHS health care services. *Id.* It was only .07 percent of the \$258 billion in combined federal and state expenditures in fiscal year 2002.

Medicaid is an especially important program for Indians because of their disproportionate poverty and for Americans generally. Due to the limitations in Medicare, it is the only source of payment for prescription drugs and for long term care for most elders in America. Since the advent of welfare reform, it is increasingly disconnected from other public assistance programs with some children being eligible up to 200 percent of the poverty level.

Although the way states reimburse IHS and tribal health programs varies widely, for most hospital and clinic based services reimbursement is made on the basis of the simplified encounter rates described above. Again these rates assure that some of the cost of the facility are covered and they minimize the complexities of billing and preparing cost reports. For these facility-based services states are reimbursed 100 percent by CMS. The fact that states can count on this level of reimbursement has generated much more positive working relationships between IHS and tribal health programs and the states than generally exist over other issues. While the financial incentive is not a uniform guarantee of cooperation, it is generally effective and has led to significantly more cooperation, especially in states with many tribes and relatively large numbers of Indians.

2/ "Native Americans and Medicaid: Coverage and Financing Issues," Andy Schneider and JoAnn Martinez, the Center on Budget and Policy Priorities for the Kaiser Commission of the Future of Medicaid, December 1997, p. 2.

The Need for Further Change.

The Indian Health Service and tribal health programs reliance on third-party revenues has grown substantially, as direct appropriations have failed to keep up. For some tribal health programs, more than half of the budget for delivery of health care now must be generated through third-party revenues. This poses huge challenges and new risks. The proposed amendments to the IHCIA address these, as well as eliminating barriers that are currently found in the program.

As the National Steering Committee undertook to consider changes needed to the provisions of the Act relating to access, it had to consider many factors. It helps to understand how relatively constrained its requests are, if one considers the following:

- The United States owes a duty to American Indians and Alaska Natives to provide them with health care. As Senator Inouye has often commented, Indians have the first pre-paid health plan in the United States – paid for with their lands and resources.
- Congress determined that its obligations to provide this health care could best be met by a combination of direct appropriations and authorizations for IHS and tribal health programs to be reimbursed for the health services they provide. Resources that are not needed to manage direct appropriations have been and continue to be devoted to pursuing these reimbursements.
- The total funds available for direct delivery of health services from direct appropriations and third-party recovery still provides on a per capita basis not much more than half of the per capita amount spent by the Federal Employee Health Benefit Plan for a much healthier population. There is no point in the foreseeable future when the combination of funds will come close to meeting the need for health care of American Indians and Alaska Natives.
- Since the 1970s when recovery from Medicare and Medicaid were first authorized, there has been a revolution in health care delivery; one that moved patients out of inpatient facilities and instead relies on outpatient services, ambulatory surgeries, and home- and community-based services. The “facility” based model of recovery initially authorized fails to provide adequately for changes in delivery that have occurred.
- American Indians and Alaska Natives “continue to suffer the highest rates of unemployment and poverty;” 31.2 % live in poverty. The unemployment rate is nearly 50% while the national average is 5.8%. Health status continues to be poor and is most striking with regard to diabetes, tuberculosis, alcoholism and fetal alcohol syndrome.^{3/}

3/ Letter from the Chairman and Vice-Chairman of the Senate Committee on Indian Affairs to the Chairman and Ranking Member of the Committee on the Budget, United States Senate, March 11, 2003.

- Improving life expectancy will increase health care costs as the population ages.

Another consideration also guided the thinking of the NSC. Both Medicare and Medicaid are riddled with special provider types (federally qualified health centers, rural health centers, critical access hospitals, disproportionate share hospitals, teaching hospitals, to name just a few) and for each there are special reimbursement rules. These special rules are designed to assure that a certain population will have access to care or that a certain objective of the program will be achieved. The NSC seeks only to assure that similar consideration is given to ensuring that these federally funded health insurance programs treat Indian programs similarly – by ensuring that the special conditions under which they operate are taken into account.

Having been compelled to invest in the means to participate in Medicare and Medicaid, tribes simply want to assure that the investment gives them full access to the benefits of the programs, not merely cut-outs designed nearly three decades ago.

Achieving the objectives of full participation in Medicare and Medicaid is no easy task. As the background discussion demonstrates, the programs are complex. They are outside the ordinary experience of tribal leaders and the jurisdiction of those committees of Congress with whom tribal leaders most often work. The National Steering Committee did not allow those factors to be a barrier to putting together a restrained package of proposed improvements. Neither should the Congress allow the relative insignificance of the program changes (when compared to massive changes like the addition of a Medicare Prescription Drug benefit currently being considered in conference, to be an excuse to not consider the proposals. While true, not even a “rounding error” in either the Medicaid or Medicare budget, the fiscal and programmatic impact for Indian health programs can be profound.

Conclusion

A section-by-section analysis of the changes found in H.R. 2440 and the differences between it and S. 556 is attached as an addendum. The analysis is accompanied by brief commentary. I hope it will help explain the purpose of each proposed amendment to the current law. I also hope it will dispel the impression that huge changes are being sought. In fact, the true change could occur only if the funds necessary to keep the commitments of the United States to provide health care to American Indians and Alaska Natives were made available.

In the meantime, swift action to improve access to care by American Indians and Alaska Natives to health programs operated by the Indian Health Service, tribes, and urban Indian organizations by making increased access to federally funded health insurance plans is the next best thing.

Thank you for your consideration. I will be glad to try to respond to your questions, and, if I can't find someone who can.

**Section-by-Section Analysis of
Title IV and Amendments to Medicare & Medicaid
in H.R. 2440 and S. 556,
Reauthorizations of the Indian Health Care Improvement Act^{1/}**

The 1999 National Steering Committee (NSC) Draft was incorporated almost without change into S. 556, a bill to reauthorize the Indian Health Care Improvement Act (IHCIA). In the three years that have passed since the NSC did its initial work, the NSC has taken the opportunity to respond to concerns expressed by the Department of Health and Human Services (HHS) regarding S. 212, which was the predecessor to S. 556, and, under the director of Representative Don Young, the prime sponsor of H.R. 2440, to work with the House Office of Legislative Counsel to clarify the NSC intent and improve the drafting. All of these changes are incorporated into H.R. 2440.

The NSC has endorsed a request that the Senate substitute Title IV, Access to Health Services, and Sections 4 and 5 of H.R. 2440 for the parallel provisions of S. 556. Accordingly, this section by section analysis addresses principally H.R. 2440 with only occasional comments about the corresponding sections in S. 556. The reasons for not including certain provisions of S. 556 in H.R. 2440 are discussed in somewhat more detail.^{2/}

Title IV. Access to Health Services.

Sec. 401. Treatment of Payments under Social Security Act Health Care Programs. This section consolidates multiple sections regarding Medicare and Medicaid into a single simplified provision.

Subsection (a), Disregard of Medicare, Medicaid, and SCHIP Payments in Determining Appropriations, continues the prohibition against consideration of Medicare, Medicaid and SCHIP funds in determining appropriations for the provision of health care and services to Indians.

Subsection (b), Nonpreferential Treatment, continues the requirement that no preference be given to an Indian with Medicare, Medicaid, or SCHIP over an Indian with no such coverage.

Subsection (c), Use of Funds, continues the “special fund” maintained by IHS for receipt of payments from Medicare, Medicaid, and SCHIP to IHS and tribal health programs that have not opted to receive payments directly. It adds a requirement that 100 percent of the receipts must be returned to the Service Unit from which the funds were generated. It maintains the requirement that the funds be used first to maintain the standards applicable to conditions for receipt of such funds imposed under the Social Security Act and provides that any other receipts be used in consultation with the tribes being served to reduce health resources deficiencies.

1/ This section-by-section analysis was drafted initially as an addendum to testimony provided by Myra M. Munson to the Senate Committee on Indian Affairs on July 23, 2003.

2/ A side-by-side comparison of the two bills and the 1999 NSC Draft accompanied with some limited notes has been provided to Committee staff to assist in the ease of comparing these different versions.

Subsection (d), Direct Billing, continues the authorization for tribal health programs to directly bill and receive payments from Medicare, Medicaid, and SCHIP. S. 556 differs from the initial NSC Draft in that it imposes the conditions initially approved by the Congress when it made the Direct Billing Demonstration permanent and extended the authority to other tribal health programs. These include obtaining approval from IHS and submitting reports. H.R. 2440 eliminates these requirements. It makes the payments subject to auditing requirements imposed on tribal health programs and requires that the receipts be used to satisfy conditions of participation, then for improvements in health care facilities and tribal health programs, other health care-related purposes, and otherwise to achieve the objectives provided in section 3 of the Act.

Commentary. IHS informally has expressed reservations about eliminating its role in approving the tribal decision to directly bill and receive funds, although they acknowledge that they have never rejected an application. The elimination of the extra requirements is justified by the experience demonstrated by tribes both during the demonstration and since. To continue them merely continues bureaucratic oversight that has not demonstrated any positive outcome for the program.

Sec. 402. Grants to and Funding Agreements with the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

Subsections (a), Indian Tribes and Tribal Organizations, and (b), Conditions, continue the authorization for grants to assist Indians to enroll for benefits under Medicare, Medicaid, and adds SCHIP and authorizes payment of premiums, based on financial need as determined by the tribe or tribes being served.

Subsection (c), Agreements Relating to Improving Enrollment of Indians under Social Security Act Programs, continues authority for the Secretary of HHS to enter into agreements under which tribal health programs may receive and process applications for Medicare, Medicaid, and SCHIP. New language also allows the Secretary to enter into such agreements with urban Indian organizations and allows all the agreements to provide for reimbursement of outreach and enrollment efforts. New provisions also allow States to enter into such agreements with tribes and tribal organizations, including reimbursement of costs. This section also protects current arrangements between States and tribes occurring under the Medicaid program. These arrangements are generally referred to as Medicaid administrative match agreements.

Subsection (d), Facilitating Cooperation, provides the Secretary with the duty to facilitate agreements under (c).

Subsection (e), Application to Urban Indian Organizations, permits grants under (a) to be awarded to urban Indian organizations.

Commentary. The high rate of poverty among Indians is not reflected by their participation in Medicare, Medicaid, and SCHIP. Expansion of the role of tribes, tribal organizations and urban Indian organizations is expected to improve access.

Sec. 403. Reimbursement from Certain Third Parties of Costs of Health Services.

Subsection (a), Right of Recovery, continues to provide a right of recovery by the IHS, tribal health programs, and now urban Indian organizations, from all insurers. It clarifies existing law regarding the amount third parties must pay and extends the duty explicitly to health maintenance organizations, employee benefit plans, third-party tortfeasors and any other responsible or liable third party.

Subsection (b), Limitations on Recoveries from States, continues to limit the right of recovery against a State unless the services were covered under workers' compensation laws or no-fault automobile accident insurance plan or program.

Subsection (c), Nonapplication of Other Laws, limits the effect of State and local laws on the right of recovery.

Subsection (d), No Effect on Private Rights of Action, continues the assurance that the right of recovery provided for above does not interfere with any rights of the individual patient.

Subsection (e), Enforcement, provides for the means of enforcement and modifies the notice requirement to the patient to require that reasonable efforts be made in the event litigation is required.

Subsection (f), Limitation, amends the limitation against IHS billing a tribe's self-insurance plan by permitting such billing if the tribe has authorized it. S. 556 prohibits not only IHS from such billing, but also tribes that have taken over a program from the IHS under the Indian Self-Determination and Education Assistance Act.

Commentary. The NSC opposes the change made in S. 556. It could substantially negatively affect the revenue stream of tribal health programs without providing for any replacement funds. While there is justification for a limitation on billing by IHS of a tribal self-insurance plan when IHS directly operates the health program, extending the limitation to tribally operated health programs interferes with the tribe's exercise of self-determination and has the potential to diminish access to care.

Subsection (g), Costs and Attorneys' Fees, provides a new right for a prevailing plaintiff to recover reasonable attorneys' fees and costs.

Subsection (h), Right of Action against Insurers, HMOs, Employee Benefit Plans, Self-Insurance Plans, and Other Health Care Plans or Programs, clarifies that the right of action under (a) extends not only to recovery from insurance companies, but also health maintenance organizations, employee benefit plans, self-insurance plans (except as provided in (f)), managed care plans, and other health care plans that fail or refuse to pay. against managed care plans.

Subsection (i), Nonapplication of Claims Filing Requirements, is a new provision that eliminates burdensome claims processing requirements by requiring payment whenever a claim is submitted that satisfies HIPAA requirements.

Subsection (j), Application to Urban Indian Organizations, is a new provision that extends the rights under this section to urban Indian organizations.

Subsection (k), Statute of Limitations, is a new provision that provides for a specific statute of limitations on the same basis as applies to claims by IHS.

Subsection (l), Savings, is a new provision clarifying that the rights provided for in this section do not diminish any rights that might be available under any applicable law, including medical lien laws and the Federal Medical Care Recovery Act.

Commentary. The new provisions of this section are borne of experience in trying to enforce the existing rights of recovery. They are intended to clarify existing law and anticipate the newest ways in which insurers will attempt to avoid reimbursing for the services provided to their insureds.

Sec. 404. Crediting of Reimbursements. Provides that the reimbursements received will be credited to the entity that generated them and that they may be used as provided under section 401. It continues a prohibition on offsetting the funds received under section 403 against the amount of funds otherwise due any service unit.

Sec. 405. Purchasing Health Care Coverage. Eliminates references to a study regarding tribal purchase of health care coverage and substitutes general authority for such purchases.

Sec. 406. Sharing Arrangements with Federal Agencies.

Subsection (a), Authority, continues the authority for the Secretary of HHS to enter into agreements with the Departments of Veterans Affairs or Defense to share facilities and service. New language requires consultation with the affected Indian tribes.

Subsection (b), Limitations, imposes limitations on such agreements to assure that they do not result in impairing services to the IHS beneficiaries or the access of any veteran to services of the V.A.

Subsection (c), Reimbursement, is a new provision that makes the IHS the payor of last resort vis-a-vis the Veterans Affairs.

Sec. 407. Payor of Last Resort. This new section provides that IHS, tribal health programs, and urban Indian organizations are the payor of last resort notwithstanding any other federal, state, or local law to the contrary.

Sec. 408. Nondiscrimination in Qualifications for Reimbursement for Services. This new section expands a current provision that exempts IHS and tribal health programs from state and local licensing and other requirements so long as the program meets the quality standards recognized by the Secretary for furnishing such services.

Section 409. Consultation.

Subsection (a), National Indian Technical Advisory Group (TAG), is a new provision that requires the formation by the Secretary of a Tribal Technical Advisory Group (TAG) regarding Medicare, Medicaid, and SCHIP. The TAG would represent each of the 12 IHS service areas and the national organizations. It would provide advice to the Secretary regarding the way programs of CMS will affect IHS, tribal health programs, and urban Indian organizations, and about when there is a need for the Secretary to engage in more formal consultation. The TTAG would meet at least quarterly and not be subject to the Federal Advisory Committee Act.

***Commentary.** CMS has been working administratively to respond to the requests from the National Indian Health Board, the National Congress of American Indians, and the Tribal Self-Governance Advisory Work Group to form a technical work group, however absent the proposed legislative action, under FACA (and the exceptions to it), the TAG must be comprised of tribal leaders or their employees. In the highly technical area of Medicare, Medicaid and SCHIP, tribal leaders, like the governors and legislators of states, rely on technical advisors to work through the details and distill the issues for their consideration through more formal consultation. Unlike states, which are funded by CMS to maintain Medicaid programs, tribes often combine resources to employ consultants to assist their direct health care provider staff with these matters. Effective communication about these programs requires that tribal leaders have the freedom to designate who they want to participate on their behalf in technical discussions. This apparently requires legislation.*

Subsection (b), Solicitation of Medicaid Advice, is a new section that requires states in which there are Indian health programs to consult with those programs on a regular basis. It permits the cost of carrying out the requirements of this subsection to obtain administrative reimbursement from HHS under section 1903(a) of the Social Security Act.

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

Subsection (a), Authorization for Arrangements, is a new section that provides discretionary authority for the Secretary to enter into agreements with the state and the IHS or tribes under which a portion of the funds due a state can be made available to the IHS or a tribe that is providing services to individuals who are covered under the state's SCHIP, whether it is carried out through Medicaid or otherwise.

Subsection (b), Entering into Arrangements, is a new provision that authorizes the Secretary to transfer unexpended state allocations on a proportional basis to the IHS or a tribal health programs for the purpose of providing child health or other assistance to individuals served by the IHS or tribal health program consistent with the purposes of SCHIP.

***Commentary.** Both of these provisions are discretionary. The proportionate amounts provided for under (b) are almost certainly insignificant in relationship to the overall SCHIP funding and the unexpended allocations. While small from a state perspective, however, such funding as might be made available under this new section could have a very powerful effect on expanding access to health services by Indian children.*

Sec. 411. Social Security Act Sanctions.

Subsection (a), Requests for Waiver of Sanctions, is a new provision that extends the right states have to seek a waiver of sanctions against health providers to tribal health programs.

Commentary. This new provision was drafted to address a real situation in which IHS was willing to assist a tribal health program in supervising a board certified physician who was willing to work in a very rural health clinic that had been served previously almost exclusively by locum tenens doctors. Unfortunately, the physician was subject to a one year sanction that prevented him from working in any federally funded position absent a waiver. HHS demurred to grant the waiver, although all the substantive conditions for granting it had been satisfied, because CMS regulations permitted only states to seek a waiver of such a sanction and the state in this case would not. HHS has informally commented that this is a limitation that could be resolved through regulations, but it appears that it has not been. Although this situation arises rarely, tribal health programs should not be dependent on the cooperation of the state in which their program is carried out in order to seek a remedy from a federal agency.

Subsection (b), Safe Harbor for Transactions between and among Indian Health Care Programs, is a new provision that authorizes certain safe harbors for transactions among IHS, tribal health programs, and urban Indian organizations, and for purposes of providing necessary transportation and housing and paying certain costs for their patients.

Commentary. This very narrowly written safe harbor is intended to eliminate any ambiguity about whether tribal health programs can continue to share resources after assuming the programs from the IHS. Such interactions are an integral part of the Indian health system funded by IHS and are essential to maintaining continuity of care for patients and efficient, cost effective operations.

Sec. 412. Cost Sharing.

Subsection (a), Coinsurance, Copayments, and Deductibles, is a new provision that eliminates cost sharing requirements for patients serves in, or upon a referral from, the IHS or a tribal or urban Indian organization health program, and provides that the provider will not have its reimbursement reduced by the value of the otherwise applicable co-pay or deductible.

Subsection (b), Exemption from Medicaid and SCHIP Premiums, is another new provision that exempts Indians from the cost of premiums under the Medicaid and SCHIP programs.

Commentary. CMS has determined that Indian children are exempt from certain SCHIP premiums, however it has not extended that protection to Medicaid programs that may impose premiums. This would clarify and codify the exemption.

Subsection (c), Medically Needy Program Spend-Down, is a new provision that provides that costs incurred by IHS and tribal health programs delivering care to an Indian will be attributed to the Indian for the purposes of establishing Medicaid eligibility under Medically needy options.

Subsection (d), Limitation on Medical Child Support Recovery, is a new provision that limits medical child support recovery under circumstances in which the contract health services program would have paid for the care, but for Medicaid or SCHIP eligibility.

Commentary. This is a very narrowly crafted provision that is intended to protect the poorest IHS beneficiaries and to achieve equity among all IHS beneficiaries regardless of whether they are Medicaid eligible or not.

Subsection (e), Continuation of Current Law Protections of Certain Indian Property from Medicaid Estate Recovery, is a new provision that protects certain trust properties and property of unique religious or cultural significance or that is necessary to support subsistence or traditional lifestyle from estate recovery rules.

Commentary. This provision codifies with a small expansion existing CMS policy. It is intended to reassure elders that they make use the benefits of the Medicaid program without the risk that their heirs will lose access to this kind of uniquely Indian property. The possibility that they might have to trade their birthright in order to obtain health care they were guaranteed by treaties, executive orders, and laws acts as a nearly insurmountable barrier to access to Medicaid and causes many Indian elders to forego needed care.

Sec. 413. Treatment under Medicaid Managed Care.

Subsection (a), Payment for Services Furnished to Indians, is a new provision that requires managed care providers to reimburse IHS, tribal health programs, and urban Indian organizations for care provided to their beneficiaries at a rate not less than that paid to the managed care entity's preferred providers or otherwise negotiated.

Subsection (b), Offering of Managed Care, is a new provision that requires states that elect to offer Medicaid through managed care to permit the IHS, tribal health programs, or urban Indian organizations that meet quality standards to be a managed care provider for the Indians it otherwise serves, without regard to other requirements that might otherwise apply.

Sec. 414. Navajo Nation Medicaid Agency. This is a new section that provides authority for the Secretary to treat the Navajo Nation as a State for the purposes of the Medicaid program and SCHIP.

SECTIONS AMENDING THE SOCIAL SECURITY ACT.

These amendments provide expanded, albeit narrowly crafted, opportunities for recovery by IHS, tribal health programs and urban Indian organizations.

Section 4. Amendments to Medicare Program.

Subsection (a), Expansion of Medicare Payment for All Covered Services Furnished by Indian Health Programs, provides for Indian health programs to be reimbursed for all Medicare services they provide, including all Part B services, rather than only for hospital and skilled nursing care and certain Part B services.

Subsection (b), Limitation on Charges for Hospital Contract Health Services Provided to Indians by Medicare Participating Hospitals, prohibits hospitals enrolled as Medicare providers charging IHS and tribal contract health programs more than Medicare reimburses. It applies to both inpatient and outpatient hospital services.

Subsection (c), Medicare Coverage of Services of Community Health Aides or Practitioners, provides for Medicare reimbursement for services provided by community health aides and practitioners. These services are currently reimbursed by Medicaid under the approved State Plan for Alaska. In the more than 100 Alaska Native villages, community health aides, who are a special provider type currently authorized only for Alaska and certified by IHS, are the only health provider in the community.

Subsection (d), Continuation of Special Treatment for Collaborative Arrangements between Indian Health Programs and Hospital Outpatient Departments, extends current rules regarding collaborative arrangements between certain outpatient clinics and inpatient hospitals within the Indian health system. These arrangements allow certain clinics that would not otherwise be considered “provider-based” under Medicare to continue to be treated as if they are for reimbursement purposes.

Subsection (e), Coverage of Visiting Nurse Services of Tribal Clinics, expands coverage for visiting nurse services by treating the programs of IHS and tribal health programs as if they were rural health clinics operating in shortage areas.

Subsection (f), Medicare Payment for Outpatient Clinics, provides for encounter rate recovery for all IHS and tribal outpatient clinics.

***Commentary.** This is an especially important provision to ensure equity of reimbursement in the IHS system. In those IHS service areas in which there are no hospitals, such as all of Idaho, Washington, Oregon, and California, all of the clinics are freestanding. As a result the basic cost of operating their program is not included in any reimbursement. The only alternative is for the clinic to bill as a federally qualified health center, which would require individual cost reports and is subject to the limitations on recovery that result in the reimbursement being demonstrably less than cost.*

Subsection (g), Review of Medicare and Medicaid Payment Systems, provides for a study of Medicare and Medicaid payment systems and continues the right of IHS and tribal health programs to be reimbursed as they currently are until prohibited by Congress.

***Commentary.** In the 1999 NSC Draft, and still in section 202 of S. 556, there is a provision to create a new provider type, a Qualified Indian Health Program (QIHP), for which reimbursement was required to cover all reasonable costs and to permit negotiation of rates to allow for increased flexibility. HHS objected to this and the Congressional Budget Office (CBO) score was the highest of any provision of the earlier draft. In an effort to respond to Administration concerns, the NSC endorsed an alternative, which is to maintain the status quo while a study of payment methodology is carried out. There are many special provider types in the Medicare and Medicaid programs; each designed to address a special challenge in assuring access to care. While it still seems the best solution to the NSC, a study will provide information upon which Congress can assess the situation more accurately.*

Section 5. Amendments to Medicaid and SCHIP.

Subsection (a), Expansion of Medicaid Payment for All Covered Services Furnished by Indian Health Programs, provides for Indian health programs to be reimbursed for all Medicaid and SCHIP services they provide. The principal effect is to eliminate reference to “facilities.” It also continues to authorize the Secretary to enter into agreements with states regarding reimbursement to the state for services provided by IHS, tribal health programs and urban Indian organizations.

Commentary. The expansion is an especially important clarification. The base of health care has changed since Medicaid recovery was first authorized in 1976. It is no longer “facility-based,” but instead is often provided in the home and community.

Subsection (b), Seeking Advice from Indian Health Programs, requires states to consult with IHS, tribes and tribal health programs and urban Indian organizations pursuant to section 409(b) of the IHCA.

Subsection (c), SCHIP Treatment of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, provides for a 100% FMAP for all SCHIP programs, not just those carried out through Medicaid.

Provisions Found in S. 556 that Are Not in H.R. 2440.

A number of provisions found in S. 556 and the 1999 NSC Draft have been deleted or substantially recrafted. Mostly these respond to concerns about the cost or complexity of the provisions, but in some cases events have simply overtaken the initial proposal. These sections of S. 556 are discussed below.

Sec. 412. Tuba City Demonstration Project. This section was deleted because the Tuba City service unit is now under tribal management and the limitations that applied to IHS, which this section relieved, are not applicable to the tribe.

Sec. 414(b). Rulemaking. In this section, CMS was required to participate in negotiated rulemaking with tribes with regard to any regulations necessary to implement the provisions of Title IV of the IHCLIA. HHS objected and the NSC agreed to withdraw it.

Sec. 416. Limitation of Secretary's Waiver Authority. This section limited certain waivers that would affect Indians. The limitation has already gone into effect.

Sec. 419(b)(2). Medicare Enrollment Premium Penalties. The NSC sought to prevent Indians from being charged late enrollment penalties that apply in the Medicare program to individuals who do not sign up for Medicare Part B at the first opportunity. Such penalties seem inconsistent with the right to access health care promised to Indians. However, in response to objections from HHS, the NSC agreed to drop this provision.

Sec. 429. Managed Care. Subsections (e), (f), (g), and (i) have been dropped for various reasons.

Title II.

Sec. 202. Qualified Indian Health Program. As noted in the discussion of section 4(g) of H.R. 2440, the creation of a new provider type was deleted in favor of a study of reimbursement methodology.

Sec. 212. FMAP for Services Provided by Indian Health Programs. Again in response to objections from HHS and the size of the CBO score, the NSC agreed to withdraw its proposed clarification of the meaning of the current provision that reimburses state Medicaid programs 100 percent of the their payments to IHS and tribal providers. The NSC still strongly supports this provision, which even in its limited application, has worked to substantially improve state/tribal relations and improve access to American Indians and Alaska Natives.