To improve the implementation of the Federal responsibility for the care and education of Indian people by improving the services and facilities of Federal health programs for Indians and encouraging maximum participation of Indians in such programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 11, 2003

Mr. Young of Alaska (for himself, Mr. Hayworth, Mr. Renzi, Mr. Cole, Mr. Hunter, Mr. McKeon, Mr. Pallone, Mr. Rahall, Mr. George Miller of California, Mr. Kildee, Mr. Dingell, Mr. Waxman, Mr. Rangel, Mr. Conyers, Mr. Oberstar, Mr. Grijalva, Ms. Millender-McDonald, Mr. Frost, Mr. Kennedy of Rhode Island, Mr. Frank of Massachusetts, Mr. Filner, Mr. Honda, Mr. Carson of Oklahoma, Mr. Allen, Mr. Abercrombie, Ms. Lee, Mrs. Napolitano, Mr. Faleomavaega, Ms. McCollum, Mr. Towns, Mr. Udall of New Mexico, Mr. Udall of Colorado, Mr. Kind, Mr. Lantos, Mr. Inslee, Mr. Stupak, Mr. Baca, Ms. Kilpatrick, Mrs. Christensen, Mr. Blumenauer, and Ms. Norton) introduced the following bill; which was referred to the Committee on Resources, and in addition to the Committees on Energy and Commerce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve the implementation of the Federal responsibility for the care and education of Indian people by improving the services and facilities of Federal health programs for Indians and encouraging maximum participation of Indians in such programs, and for other purposes.
Be it enacted by the Senate and House of Representa-
tives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Indian Health Care Improvement Act Amendments of 2003”.

SEC. 2. INDIAN HEALTH CARE IMPROVEMENT ACT AMEND-
ED.

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

“SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

“(a) Short Title.—This Act may be cited as the ‘Indian Health Care Improvement Act’.

“(b) Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Indian Health Care Improvement Act amended.
"Sec. 1. Short title; table of contents.
"Sec. 2. Findings.
"Sec. 3. Declaration of National Indian health policy.
"Sec. 4. Definitions.

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

"Sec. 101. Purpose.
"Sec. 102. Health Professions Recruitment Program for Indians.
"Sec. 103. Health Professions Preparatory Scholarship Program for Indians.
"Sec. 104. Indian health professions scholarships.
"Sec. 105. American Indians into psychology program.
"Sec. 106. Funding for tribes for scholarship programs.
"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. Indian recruitment and retention program.
"Sec. 114. Advanced training and research.
"Sec. 115. Quentin N. Burdick American Indians into nursing program.
"Sec. 116. Tribal cultural orientation.
"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 programs.
"Sec. 124. Treatment of scholarships for certain purposes.
"Sec. 125. National Health Service Corps.
"Sec. 126. Substance abuse counselor educational curricula demonstration programs.
"Sec. 127. Mental health training and community education programs.
"Sec. 128. Designation of shortage areas.
"Sec. 129. Authorization of appropriations.

"TITLE II—HEALTH SERVICES

"Sec. 201. Indian Health Care Improvement Fund.
"Sec. 203. Health promotion and disease prevention services.
"Sec. 204. Diabetes prevention, treatment, and control.
"Sec. 205. Shared services for long-term care.
"Sec. 206. Health services research.
"Sec. 207. Mammography and other cancer screening.
"Sec. 208. Patient travel costs.
"Sec. 209. Epidemiology centers.
"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 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. Notification of provision of 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. Sanitation facilities.
"Sec. 303. Preference to Indians and Indian firms.
"Sec. 304. Expenditure of nonservice funds for renovation.
"Sec. 305. Funding for the construction, expansion, and modernization of small ambulatory care facilities.
"Sec. 306. Indian Health Care Delivery Demonstration Project.
"Sec. 307. Land transfer.
"Sec. 308. Leases, contracts, and other agreements.
"Sec. 309. Loans, loan guarantees, and loan repayment.
"Sec. 310. Tribal leasing.
"Sec. 311. Indian Health Service/tribal facilities joint venture program.
"Sec. 312. Location of facilities.
"Sec. 313. Maintenance and improvement of health care facilities.
"Sec. 314. Tribal management of federally owned quarters.
"Sec. 315. Applicability of Buy American Act requirement.
"Sec. 316. Other funding for facilities.
"Sec. 317. Authorization of appropriations.

"TITLE IV—ACCESS TO HEALTH SERVICES

"Sec. 401. Treatment of payments under Social Security Act health care programs.
"Sec. 402. Grants to and funding agreements with the Service, Indian tribes, tribal organizations, and urban Indian organizations.
"Sec. 403. Reimbursement from certain third parties of costs of health services.
"Sec. 404. Crediting of reimbursements.
"Sec. 405. Purchasing health care coverage.
"Sec. 407. Payor of last resort.
"Sec. 408. Nondiscrimination in qualifications for reimbursement for services.
"Sec. 409. Consultation.
"Sec. 410. State children’s health insurance program (SCHIP).
"Sec. 411. Social Security Act sanctions.
"Sec. 412. Cost sharing.
"Sec. 413. Treatment under Medicaid managed care.
"Sec. 414. Navajo Nation Medicaid agency.
"Sec. 415. 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. Eligibility for services.

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. Memoranda 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.
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 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. Severability provisions.
Sec. 815. Establishment of National Bipartisan Commission on Indian Health Care Entitlement.
Sec. 816. Appropriations; availability.
Sec. 817. Confidentiality of medical quality assurance records: qualified immunity for participants.
“Sec. 2. FINDINGS.

“Congress finds the following:

“(1) Federal delivery of health services and funding of Indian and Urban Indian Health Programs to maintain and improve the health of Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with Indians, as reflected in the Constitution, treaties, Federal statutes and the course of dealings of the United States with Indian Tribes and the United States’ resulting government-to-government relationship with Indian Tribes and trust responsibilities and obligations to Indians.

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

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

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

“(5) A major national goal of the United States
is to provide the quantity and quality of health serv-
ices which will permit the health status of Indians
regardless of where they live to be raised to the
highest possible level that is no less than that of the
general population and to provide for the maximum
participation of Indian Tribes, Tribal Organizations,
and Urban Indian Organizations in the planning, de-
delivery and management of those health services.

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

“(7) Despite such services, the unmet health
needs of Indians remain alarmingly severe and the
health status of Indians is far below the health sta-
tus of the general population of the United States.

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

“SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POL-
ICY.

“Congress hereby declares that it is the policy of this
Nation, in fulfillment of its special trust responsibilities
and legal obligations to Indians—

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

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

“(3) to the greatest extent possible, to allow In-
dians to set their own health care priorities and es-
ablish goals that reflect their unmet needs;

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

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

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

“SEC. 4. DEFINITIONS.

“For purposes of this Act:

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

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

“(3) The term ‘California Indians’ shall mean those Indians who are eligible for health services of the Service pursuant to section 806.
“(4) The term ‘community college’ means—

“(A) a tribal college or university, or

“(B) a junior or community college.

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

“(6) The term ‘Department’ means, unless otherwise designated, the Department of Health and Human Services.

“(7) The term ‘Director’ means the Director of the Indian Health Service.

“(8) The term ‘disease prevention’ means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including, but not limited to—

“(A) controlling—

“(i) development of diabetes;

“(ii) high blood pressure;

“(iii) infectious agents;

“(iv) injuries;

“(v) occupational hazards and disabilities;
“(vi) sexually transmittable diseases;

and

“(vii) toxic agents; and

“(B) providing—

“(i) fluoridation of water; and

“(ii) immunizations.

“(9) The term ‘fund’ or ‘funding’ means the transfer of moneys from the Department to any eligible entity or individual under this Act by any legal means, including Funding Agreements, contracts, memoranda of understanding, contracts pursuant to section 23 of the Act of April 20, 1908 (25 U.S.C. 47; popularly known as the ‘Buy Indian Act’), or otherwise.

“(10) The term ‘Funding Agreement’ means any agreement to transfer funds for the planning, conduct, and administration of programs, services, functions, and activities to Indian Tribes and Tribal Organizations from the Secretary under the Indian Self-Determination and Education Assistance Act.

“(11) The term ‘health profession’ means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, op-
tometry, pharmacy, psychology, public health, social
work, marriage and family therapy, chiropractic
medicine, environmental health and engineering, al­
lied health professions, and any other health profes­
sion.

“(12) The term ‘health promotion’ means—

“(A) fostering social, economic, environ­
mental, and personal factors conducive to
health, including raising public awareness about
health matters and enabling the people to cope
with health problems by increasing their knowl­
edge and providing them with valid information;
“(B) encouraging adequate and appro­
priate diet, exercise, and sleep;
“(C) promoting education and work in con­
formity with physical and mental capacity;
“(D) making available suitable housing,
safe water, and sanitary facilities;
“(E) improving the physical, economic, cul­
tural, psychological, and social environment;
“(F) promoting adequate opportunity for
spiritual, religious, and Traditional Health Care
Practices; and
“(G) providing adequate and appropriate
programs, including, but not limited to—
“(i) abuse prevention (mental and physical);
“(ii) community health;
“(iii) community safety;
“(iv) consumer health education;
“(v) diet and nutrition;
“(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;
“(vii) environmental health;
“(viii) exercise and physical fitness;
“(ix) avoidance of fetal alcohol disorders;
“(x) first aid and CPR education;
“(xi) human growth and development;
“(xii) injury prevention and personal safety;
“(xiii) mental health;
“(xiv) personal health and wellness practices;
“(xv) personal capacity building;
“(xvi) prenatal, pregnancy, and infant care;
“(xvii) psychological well-being;
“(xviii) reproductive health and family planning;

“(xix) safe and adequate water;

“(xx) safe housing;

“(xxi) safe work environments;

“(xxii) stress control;

“(xxiii) substance abuse;

“(xxiv) sanitary facilities;

“(xxv) tobacco use cessation and reduction;

“(xxvi) violence prevention; and

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

“(13) The term ‘Indian’ shall have the meaning given that term in the Indian Self-Determination and Education Assistance Act.

“(14) The term ‘Indian Health Program’ means the following—

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

“(B) any Tribal Health Program; or
“(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of April 30, 1908 (25 U.S.C. 47), popularly known as the ‘Buy Indian Act’.

“(15) The term ‘Indian Tribe’ shall have the meaning given that term in the Indian Self-Determination and Education Assistance Act.

“(16) The term ‘junior or community college’ has the meaning given to such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

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

“(18) The term ‘Secretary’, unless otherwise designated, means the Secretary of Health and Human Services.

“(19) The term ‘Service’ means the Indian Health Service.

“(20) The term ‘Service Area’ means the geographical area served by each Area Office.
“(21) The term ‘Service Unit’ means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

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

“(23) The term ‘tribal college or university’ shall have the meaning given that term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1059e(b)(3)).

“(24) The term ‘Tribal Health Program’ means an Indian Tribe or Tribal Organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a Funding Agreement
with the Service under the Indian Self-Determination and Education Assistance Act.

“(25) The term ‘Tribal Organization’ shall have the meaning given that term in the Indian Self-Determination and Education Assistance Act.

“(26) The term ‘Urban Center’ means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

“(27) The term ‘Urban Indian’ means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

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

“(B) The individual is an Eskimo, Aleut, or other Alaskan Native.
“(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

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

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

“TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

“SEC. 101. PURPOSE.

“The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and Urban Indian Organizations involved in the provision of health services to Indians.
SEC. 102. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

“(a) In General.—The Secretary, acting through the Service, shall make funds available to public or non-profit private health entities or Tribal Health Programs to assist such entities in meeting the costs of—

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

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

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

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

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

“(b) Funding.—
“(1) APPLICATION.—Funds under this section shall require that an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe pursuant to this Act. The Secretary shall give a preference to applications submitted by Tribal Health Programs or Urban Indian Organizations.

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

“(c) DEFINITION OF INDIAN.—For purposes of this section and sections 103 and 104, the term ‘Indian’ shall, in addition to the meaning given that term in section 4, also mean any individual who is an Urban Indian.
“SEC. 103. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

“(a) Scholarships Authorized.—The Secretary, acting through the Service, shall provide scholarships to Indians who—

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

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

“(b) Purposes.—Scholarships provided pursuant to this section shall be for the following purposes:

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

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

“(1) may cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school;

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

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

“Sec. 104. Indian Health Professions Scholarships.

“(a) In General.—

“(1) Authority.—The Secretary, acting through the Service, shall make scholarships to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Services Act (42 U.S.C. 2541), except as provided in subsection (b) of this section.

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

“(3) CONTINUITY OF PRIOR SCHOLARSHIPS.—
Paragraph (2) shall not apply with respect to indi-
vidual recipients of scholarships provided under this
section (as in effect 1 day prior to the date of the
enactment of the Indian Health Care Improvement
Act Amendments of 2003) until such time as the in-
dividual completes the course of study that is sup-
ported through such scholarship.

“(4) CERTAIN DELEGATION NOT ALLOWED.—
The administration of this section shall be a respon-
sibility of the Director and shall not be delegated in
a Funding Agreement.

“(b) ACTIVE DUTY SERVICE OBLIGATION.—
“(1) OBLIGATION MET.—The active duty serv-
ice obligation under a written contract with the Sec-
retary under section 338A of the Public Health
Service Act (42 U.S.C. 254l) that an Indian has en-
tered into under that section shall, if that individual
is a recipient of an Indian Health Scholarship, be
met in full-time practice on an equivalent year-for-
year obligation, by service in one or more of the fol-
lowing:

“(A) In an Indian Health Program.
“(B) In a program assisted under title V.
“(C) In the private practice of the applica-
ble profession if, as determined by the Sec-
retary, in accordance with guidelines promul-
gated by the Secretary, such practice is situated
in a physician or other health professional
shortage area and addresses the health care
needs of a substantial number of Indians.

“(2) Obligation Deferred.—At the request
of any individual who has entered into a contract re-
ferred to in paragraph (1) and who receives a degree
in medicine (including osteopathic or allopathic med-
icine), dentistry, optometry, podiatry, or pharmacy,
the Secretary shall defer the active duty service obli-
gation of that individual under that contract, in
order that such individual may complete any intern-
ship, residency, or other advanced clinical training
that is required for the practice of that health pro-
fession, for an appropriate period (in years, as deter-
mined by the Secretary), subject to the following
conditions:
“(A) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service under this subsection.

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

“(C) The active duty service obligation will be served in the health profession of that individual in a manner consistent with paragraph (1).

“(D) A recipient of a scholarship under this section may, at the election of the recipient, meet the active duty service obligation described in paragraph (1) by service in a program specified under that paragraph that—

“(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

“(ii) serves the Indian Tribe in which the recipient is enrolled.

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

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

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

“(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

“(A) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the Area Office); or

“(B) 2 years; and

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

“(d) Breach of Contract.—

“(1) Specified Breaches.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003 if that individual—

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

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

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

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

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

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

“(4) WAIVERS AND SUSPENSIONS.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, determines that—
“(A) it is not possible for the recipient to meet that obligation or make that payment;

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

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

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

“(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.
“SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

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

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

“(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of funds provided under this section.
“(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

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

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

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

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

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

“(6) to the maximum extent feasible, uses existing university tutoring, counseling, and student support services; and
“(7) to the maximum extent feasible, employs qualified Indians in the program.

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

“(1) in an Indian Health Program;

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

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

“SEC. 106. FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.

“(a) IN GENERAL.—

“(1) FUNDING AUTHORIZED.—The Secretary, acting through the Service, shall make funds available to Tribal Health Programs for the purpose of assisting such Tribal Health Programs in educating Indians to serve as health professionals in Indian communities.
“(2) AMOUNT.—Amounts available under para-
graph (1) for any fiscal year shall not exceed 5 per-
cent of the amounts available for each fiscal year for
Indian Health Scholarships under section 104.

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

“(b) REQUIREMENTS.—

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

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

“(A) 80 percent of the costs of the scholar-
ship shall be paid from the funds made avail-
able pursuant to subsection (a)(1) provided to
the Tribal Health Program; and

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

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

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

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

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

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

“(2) provide that the amount of the scholarship—

“(A) may only be expended for—

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

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

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

“(3) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and
“(4) require the recipient of such scholarship to
meet the educational and licensure requirements ap­
propriate to each health profession.
“(e) BREACH OF CONTRACT.—
“(1) SPECIFIC BREACHES.—An individual who
has entered into a written contract with the Sec­
retary and a Tribal Health Program under sub­
section (d) shall be liable to the United States for
the Federal share of the amount which has been
paid to him or her, or on his or her behalf, under
the contract if that individual—
“(A) fails to maintain an acceptable level
of academic standing in the educational institu­
tion in which he or she is enrolled (such level
as determined by the educational institution
under regulations of the Secretary);
“(B) is dismissed from such educational
institution for disciplinary reasons;
“(C) voluntarily terminates the training in
such an educational institution for which he or
she is provided a scholarship under such con­
tract before the completion of such training; or
“(D) fails to accept payment, or instructs
the educational institution in which he or she is
enrolled not to accept payment, in whole or in
part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

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

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

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

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

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

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

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

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"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) Employment Preference.—Any individual who receives a scholarship pursuant to sections 104 or 106 shall be given preference for employment in the Service, or may be employed by a Tribal Health Program or an Urban Indian Organization, or other agencies of the Department as available, during any nonacademic period of the year.

"(b) Not Counted Toward Active Duty Service Obligation.—Periods of employment pursuant to this subsection shall not be counted in determining fulfillment of the service obligation incurred as a condition of the scholarship.

"(c) Timing; Length of Employment.—Any individual enrolled in a program, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an Urban Indian Organization during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(d) Nonapplicability of Competitive Personnel System.—Any employment pursuant to this section shall be made without regard to any competitive per-
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sonnel system or agency personnel limitation and to a po-
sition which will enable the individual so employed to re-
ceive practical experience in the health profession in which
he or she is engaged in study. Any individual so employed
shall receive payment for his or her services comparable
to the salary he or she would receive if he or she were
employed in the competitive system. Any individual so em-
ployed shall not be counted against any employment ceil-
ing affecting the Service or the Department.

“SEC. 108. CONTINUING EDUCATION ALLOWANCES.

“In order to encourage health professionals, including
community health representatives and emergency medical
technicians, to join or continue in an Indian Health Pro-
gram or an Urban Indian Organization and to provide
their services in the rural and remote areas where a sig-
nificant portion of Indians reside, the Secretary, acting
through the Service Area, may provide allowances to
health professionals employed in an Indian Health Pro-
gram or an Urban Indian Organization to enable them
for a period of time each year prescribed by regulation
of the Secretary to take leave of their duty stations for
professional consultation and refresher training courses.
“SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

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

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

“(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

“(b) DUTIES.—The Community Health Representative Program of the Service, shall—

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

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

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

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

“(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

“(4) maintain a system that provides close supervision of Community Health Representatives;

“(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

“(6) promote Traditional Health Care Practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

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

“(a) Establishment.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Service Loan Repayment Pro-
gram (hereinafter referred to as the ‘Loan Repayment Program’) in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian Health Programs and Urban Indian Organizations.

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

“(1)(A) be enrolled—

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

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

“(B) have—

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

“(ii) a license to practice a health profession;
“(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

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

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

“(D) be employed in an Indian Health Program or Urban Indian Organization without a service obligation; and

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

“(c) APPLICATION.—

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

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

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

“(d) PRIORITIES.—

“(1) LIST.—Consistent with subsection (k), the Secretary shall annually—

“(A) identify the positions in each Indian Health Program or Urban Indian Organization for which there is a need or a vacancy; and
“(B) rank those positions in order of priority.

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

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

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

“(i) individuals recruited through the efforts of a Tribal Health Program or Urban Indian Organization; and

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

“(e) RECIPIENT CONTRACTS.—

“(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).
“(2) CONTENTS OF CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

“(A) an agreement under which—

“(i) subject to subparagraph (C), the Secretary agrees—

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

“(II) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a Tribal Health Program or Urban Indian Organization as provided in clause (ii)(III); and

“(ii) subject to subparagraph (C), the individual agrees—

“(I) to accept loan payments on behalf of the individual;

“(II) in the case of an individual described in subsection (b)(1)—

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

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

“(III) to serve for a time period (hereinafter in this section referred to as the ‘period of obligated service’) equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual’s profession in an Indian Health Program or Urban Indian Organization to which the individual may be assigned by the Secretary;

“(B) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obli-
gated service agreed to by the individual under subparagraph (A)(ii)(III);

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

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

and

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

“(f) Deadline for Decision on Application.—The Secretary shall provide written notice to an individual within 21 days on—

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

“(2) the Secretary’s disapproving an individual’s participation in such Program.
“(g) PAYMENTS.—

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

“(A) tuition expenses;

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

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

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

tion—

“(A) affects the ability of the Secretary to
maximize the number of contracts that can be
provided under the Loan Repayment Program
from the amounts appropriated for such con-
tracts;

“(B) provides an incentive to serve in In-
dian Health Programs and Urban Indian Orga-
nizations with the greatest shortages of health
professionals; and

“(C) provides an incentive with respect to
the health professional involved remaining in an
Indian Health Program or Urban Indian Orga-
nization with such a health professional short-
age, and continuing to provide primary health
services, after the completion of the period of
obligated service under the Loan Repayment
Program.

“(3) TIMING.—Any arrangement made by the
Secretary for the making of loan repayments in ac-
cordance with this subsection shall provide that any
repayments for a year of obligated service shall be
made no later than the end of the fiscal year in
which the individual completes such year of service.
“(4) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

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

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

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

“(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or Urban Indian Organizations pursuant to contracts entered into under this section, shall—
“(1) ensure that the staffing needs of Tribal Health Programs and Urban Indian Organizations receive consideration on an equal basis with programs that are administered directly by the Service; and

“(2) give priority to assigning individuals to Indian Health Programs and Urban Indian Organizations that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

“(l) BREACH OF CONTRACT.—

“(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section and has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual’s behalf under the contract if that individual—

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

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

“(ii) voluntarily terminates such enrollment; or

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

“(B) is enrolled in a graduate training program and fails to complete such training program.

“(2) Other Breaches; Formula for Amount Owed.—If, for any reason not specified in paragraph (1), an individual breaches his or her written contract under this section by failing either to begin, or complete, such individual’s period of obligated service in accordance with subsection (e)(2), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula: \( A = 3Z(t-s/t) \) in which—

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

“(B) ‘Z’ is the sum of the amounts paid under this section to, or on behalf of, the indi-
vidual and the interest on such amounts which
would be payable if, at the time the amounts
were paid, they were loans bearing interest at
the maximum legal prevailing rate, as deter-
mined by the Secretary of the Treasury;

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

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

“(3) Deductions in Medicare Payments.—
Amounts not paid within such period shall be sub-
ject to collection through deductions in medicare
payments pursuant to section 1892 of the Social Se-
curity Act.

“(4) Time Period for Repayment.—Any
amount of damages which the United States is en-
titled to recover under this subsection shall be paid to
the United States within the 1-year period beginning
on the date of the breach or such longer period be-
ginning on such date as shall be specified by the
Secretary.

“(5) Recovery of Delinquency.—
“(A) IN GENERAL.—If damages described
in paragraph (4) are delinquent for 3 months,
the Secretary shall, for the purpose of recov­
ering such damages—

“(i) use collection agencies contracted
with by the Administrator of General Serv­
ices; or

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

“(B) REPORT.—Each contract for recov­
ering damages pursuant to this subsection shall
provide that the contractor will, not less than
once each 6 months, submit to the Secretary a
status report on the success of the contractor in
collecting such damages. Section 3718 of title
31, United States Code, shall apply to any such
contract to the extent not inconsistent with this
subsection.

“(m) WAIVER OR SUSPENSION OF OBLIGATION.—

“(1) IN GENERAL.—The Secretary shall by reg­
ulation provide for the partial or total waiver or sus­
pension of any obligation of service or payment by
an individual under the Loan Repayment Program
whenever compliance by the individual is impossible
or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

“(2) CANCELED UPON DEATH.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

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

“(4) BANKRUPTCY.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

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

“(1) A list of the health professional positions maintained by Indian Health Programs and Urban Indian Organizations for which recruitment or retention is difficult.

“(2) The number of Loan Repayment Program applications filed with respect to each type of health profession.

“(3) The number of contracts described in subsection (e) that are entered into with respect to each health profession.

“(4) The amount of loan payments made under this section, in total and by health profession.

“(5) The number of scholarships that are provided under section 104 and 106 with respect to each health profession.

“(6) The amount of scholarship grants provided under section 104 and 106, in total and by health profession.

“(7) The number of providers of health care that will be needed by Indian Health Programs and Urban Indian Organizations, by location and profession, during the 3 fiscal years beginning after the date the report is filed.
“(8) The measures the Secretary plans to take to fill the health professional positions maintained by Indian Health Programs or Urban Indian Organizations for which recruitment or retention is difficult.

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

“(a) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the ‘LRRF’). The LRRF shall consist of such amounts as may be collected from individuals under section 104(d), section 106(e), and section 110(l) for breach of contract, such funds as may be appropriated to the LRRF, and interest earned on amounts in the LRRF. All amounts collected, appropriated, or earned relative to the LRRF shall remain available until expended.

“(b) USE OF FUNDS.—

“(1) BY SECRETARY.—Amounts in the LRRF may be expended by the Secretary, acting through the Service, to make payments to an Indian Health Program—

“(A) to which a scholarship recipient under section 104 and 106 or a loan repayment pro-
gram participant under section 110 has been
assigned to meet the obligated service require-
ments pursuant to such sections; and

“(B) that has a need for a health profes-
sional to provide health care services as a result
of such recipient or participant having breached
the contract entered into under section 104,
106, or section 110.

“(2) By Tribal Health Programs.—A Tribal
Health Program receiving payments pursuant to
paragraph (1) may expend the payments to provide
scholarships or recruit and employ, directly or by
contract, health professionals to provide health care
services.

“(c) Investment of Funds.—The Secretary of the
Treasury shall invest such amounts of the LRRF as the
Secretary of Health and Human Services determines are
not required to meet current withdrawals from the LRRF.
Such investments may be made only in interest bearing
obligations of the United States. For such purpose, such
obligations may be acquired on original issue at the issue
price, or by purchase of outstanding obligations at the
market price.
“(d) Sale of Obligations.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

“Sec. 112. Recruitment Activities.

“(a) Reimbursement for Travel.—The Secretary, acting through the Service, may reimburse health professionals seeking positions with Indian Health Programs or Urban Indian Organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

“(b) Recruitment Personnel.—The Secretary, acting through the Service, shall assign one individual in each Area Office to be responsible on a full-time basis for recruitment activities.

“Sec. 113. Indian Recruitment and Retention Program.

“(a) In General.—The Secretary, acting through the Service, shall fund innovative demonstration projects for a period not to exceed 3 years to enable Tribal Health Programs and Urban Indian Organizations to recruit,
place, and retain health professionals to meet their staffing needs.

“(b) ELIGIBLE ENTITIES; APPLICATION.—Any Tribal Health Program or Urban Indian Organization may submit an application for funding of a project pursuant to this section.

“SEC. 114. ADVANCED TRAINING AND RESEARCH.

“(a) DEMONSTRATION PROGRAM.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian Health Program or Urban Indian Organization for a substantial period of time to pursue advanced training or research areas of study for which the Secretary determines a need exists.

“(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian Health Program or Urban Indian Organization for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after the date of the enact-
ment of the Indian Health Care Improvement Act Amend-
ments of 2003, the United States shall be entitled to re-
cover from such individual an amount to be determined
in accordance with the formula specified in subsection (l)
of section 110 in the manner provided for in such sub-
section.

"(c) EQUAL OPPORTUNITY FOR PARTICIPATION.—
Health professionals from Tribal Health Programs and
Urban Indian Organizations shall be given an equal oppor-
tunity to participate in the program under subsection (a).

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

"(a) GRANTS AUTHORIZED.—For the purpose of in-
creasing the number of nurses, nurse midwives, and nurse
practitioners who deliver health care services to Indians,
the Secretary, acting through the Service, shall provide
grants to the following:

"(1) Public or private schools of nursing.

"(2) Tribal colleges or universities.

"(3) Nurse midwife programs and advanced
practice nurse programs that are provided by any
tribal college or university accredited nursing pro-
gram, or in the absence of such, any other public or
private institutions.
“(b) USE OF GRANTS.—Grants provided under subsection (a) may be used for one or more of the following:

“(1) To recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses.

“(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

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

“(4) To provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses.

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

“(c) APPLICATIONS.—Each application for funding under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.
“(d) PREFERENCES FOR GRANT RECIPIENTS.—In providing grants under subsection (a), the Secretary shall extend a preference to the following:

“(1) Programs that provide a preference to Indians.

“(2) Programs that train nurse midwives or advanced practice nurses.

“(3) Programs that are interdisciplinary.

“(4) Programs that are conducted in cooperation with a program for gifted and talented Indian students.

“(e) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide one of the grants authorized under subsection (a) to establish and maintain a program at the University of North Dakota to be known as the ‘Quentin N. Burdick American Indians Into Nursing Program’. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

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

Such obligation shall be met by service—

“(1) in the Service;

“(2) in a program of an Indian Tribe or Tribal Organization conducted under the Indian Self-Determination Act (including programs under agreements with the Bureau of Indian Affairs);

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

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

“SEC. 116. TRIBAL CULTURAL ORIENTATION.

“(a) CULTURAL EDUCATION OF EMPLOYEES.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian Tribes in each Service Area receive educational instruction in the history and culture of such Indian Tribes and their relationship to the Service.
“(b) PROGRAM.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—

“(1) be developed in consultation with the affected Indian Tribes, Tribal Organizations, and Urban Indian Organizations;

“(2) be carried out through tribal colleges or universities;

“(3) include instruction in American Indian studies; and

“(4) describe the use and place of Traditional Health Care Practices of the Indian Tribes in the Service Area.

“SEC. 117. INMED PROGRAM.

“(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, is authorized to provide grants to colleges and universities for the purpose of maintaining and expanding the Indian health careers recruitment program known as the ‘Indians Into Medicine Program’ (hereinafter in this section referred to as ‘INMED’) as a means of encouraging Indians to enter the health professions.

“(b) QUENTIN N. BURDICK GRANT.—The Secretary shall provide one of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the ‘Quentin N.
Burdick Indian Health Programs’, unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, co­ordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b) and the Quentin N. Burdick American Indians Into Nurs­ing Program established under section 115.

“(c) REGULATIONS.—The Secretary, pursuant to this Act, shall develop regulations to govern grants pursuant to this section.

“(d) REQUIREMENTS.—Applicants for grants pro­vided under this section shall agree to provide a program which—

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

“(2) incorporates a program advisory board comprised of representatives from the Indian Tribes and Indian communities which will be served by the program;

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

“(4) provides tutoring, counseling, and support
to students who are enrolled in a health career pro-
gram of study at the respective college or university;
and

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

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

“(a) GRANTS TO ESTABLISH PROGRAMS.—

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

“(2) AMOUNT OF GRANTS.—The amount of any
grant awarded to a community college under para-
graph (1) for the first year in which such a grant
is provided to the community college shall not exceed
$100,000.
“(b) Grants for Maintenance and Recruiting.—

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

“(2) Requirements.—Grants may only be made under this section to a community college which—

“(A) is accredited;

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

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

“(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and
“(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

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

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

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

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

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

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

“(d) ADVANCED TRAINING.—

“(1) REQUIRED.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses
of study which provide advanced training for any
health professional who—

“(A) has already received a degree or di-
ploma in such health profession; and

“(B) provides clinical services on or near a
reservation or for an Indian Health Program.

“(2) MAY BE OFFERED AT ALTERNATE SITE.—
Such courses of study may be offered in conjunction
with the college or university with which the commu-
nity college has entered into the agreement required
under subsection (b)(2)(C).

“(e) FUNDING PRIORITY.—Where the requirements
of subsection (b) are met, funding priority shall be pro-
vided to tribal colleges and universities in Service Areas
where they exist.

“SEC. 119. RETENTION BONUS.

“(a) BONUS AUTHORIZED.—The Secretary may pay
a retention bonus to any health professional employed by,
or assigned to, and serving in, an Indian Health Program
or Urban Indian Organization either as a civilian employee
or as a commissioned officer in the Regular or Reserve
Corps of the Public Health Service who—

“(1) is assigned to, and serving in, a position
for which recruitment or retention of personnel is
difficult;
“(2) the Secretary determines is needed by Indian Health Programs and Urban Indian Organizations;

“(3) has—

“(A) completed 3 years of employment with an Indian Health Program or Urban Indian Organization; or

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

“(i) any Federal scholarship program;

or

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

“(4) enters into an agreement with an Indian Health Program or Urban Indian Organization for continued employment for a period of not less than 1 year.

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

“(c) Default of Retention Agreement.—Any health professional failing to complete the agreed upon
term of service, except where such failure is through no
fault of the individual, shall be obligated to refund to the
Government the full amount of the retention bonus for the
period covered by the agreement, plus interest as deter-
mined by the Secretary in accordance with section
110(l)(2)(B).

“(d) OTHER RETENTION BONUS.—The Secretary
may pay a retention bonus to any health professional em-
ployed by a Tribal Health Program if such health profes-
sional is serving in a position which the Secretary deter-
mines is—

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

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

“SEC. 120. NURSING RESIDENCY PROGRAM.

“(a) ESTABLISHMENT OF PROGRAM.—The Sec-
retary, acting through the Service, shall establish a pro-
gram to enable Indians who are licensed practical nurses,
licensed vocational nurses, and registered nurses who are
working in an Indian Health Program or Urban Indian
Organization, and have done so for a period of not less
than 1 year, to pursue advanced training. Such program
shall include a combination of education and work study
in an Indian Health Program or Urban Indian Organiza-
tion leading to an associate or bachelor’s degree (in the
case of a licensed practical nurse or licensed vocational
nurse), a bachelor’s degree (in the case of a registered
nurse), or advanced degrees in nursing and public health.

“(b) SERVICE OBLIGATION.—An individual who par-
ticipates in a program under subsection (a), where the
educational costs are paid by the Service, shall incur an
obligation to serve in an Indian Health Program or Urban
Indian Organization for a period of obligated service equal
to the amount of time during which the individual partici-
pates in such program. In the event that the individual
fails to complete such obligated service, the United States
shall be entitled to recover from such individual an amount
determined in accordance with the formula specified in
subsection (l) of section 110 in the manner provided for
in such subsection.

“SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALAS-
KA.

“(a) GENERAL PURPOSES OF PROGRAM.—Under the
authority of the Act of November 2, 1921 (25 U.S.C. 13;
popularly known as the Snyder Act), the Secretary, acting
through the Service, shall develop and operate a Commu-
nity Health Aide Program in Alaska under which the
Service—
“(1) provides for the training of Alaska Natives as health aides or community health practitioners;

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

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

“(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

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

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

“(A) combines education in the theory of health care with supervised practical experience in the provision of health care;
“(B) provides instruction and practical experience in the provision of acute care, emergency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

“(C) promotes the achievement of the health status objectives specified in section 3(2);

“(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or can demonstrate equivalent experience;

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

“(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and
“(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services.

“(c) NATIONAL COMMUNITY HEALTH AIDE PROGRAM.—The Secretary, acting through the Service, shall develop and operate a national Community Health Aide Program consistent with the requirements of this section without reducing funds for the Community Health Aide Program for Alaska.

“SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

“The Secretary, acting through the Service, shall, by funding agreement or otherwise, provide training for Indians in the administration and planning of Tribal Health Programs.

“SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.

“(a) DEMONSTRATION PROGRAMS AUTHORIZED.—The Secretary, acting through the Service, may fund demonstration programs for Tribal Health Programs to address the chronic shortages of health professionals.

“(b) PURPOSES OF PROGRAMS.—The purposes of demonstration programs funded under subsection (a) shall be—
“(1) to provide direct clinical and practical experience at a Service Unit to health profession students and residents from medical schools;

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

“(3) to provide academic and scholarly opportunities for health professionals serving Indians by identifying all academic and scholarly resources of the region.

“(c) ADVISORY BOARD.—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board composed of representatives from the Indian Tribes and Indian communities in the area which will be served by the program.

“SEC. 124. TREATMENT OF SCHOLARSHIPS FOR CERTAIN PURPOSES.

“Scholarships provided to individuals pursuant to this title shall be deemed ‘qualified Scholarships’ for purposes of section 11 of the Internal Revenue Code of 1986.

“SEC. 125. NATIONAL HEALTH SERVICE CORPS.

“(a) NO REDUCTION IN SERVICES.—The Secretary shall not—
“(1) remove a member of the National Health Service Corps from an Indian Health Program or Urban Indian Organization; or
“(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations, has ensured that the Indians receiving services from such member will experience no reduction in services.
“(b) EXEMPTION FROM LIMITATIONS.—National Health Service Corps scholars qualifying for the Commissioned Corps in the United States Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the Service when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

“SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.
“(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribal colleges and universities and eligible accredited and accessible community colleges to establish demonstration programs to develop educational curricula for substance abuse counseling.
“(b) **USE OF FUNDS.**—Funds provided under this section shall be used only for developing and providing educational curriculum for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

“(c) **TIME PERIOD OF ASSISTANCE; RENEWAL.**—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1-year period upon the approval of the Secretary.

“(d) **CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.**—Not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

“(e) **ASSISTANCE.**—The Secretary shall provide such technical and other assistance as may be necessary to en-
able grant recipients to comply with the provisions of this
section.

“(f) REPORT.—Each fiscal year, the Secretary shall
submit to the President, for inclusion in the report which
is required to be submitted under section 801 for that fis­
cal year, a report on the findings and conclusions derived
from the demonstration programs conducted under this
section during that fiscal year.

“(g) DEFINITION.—For the purposes of this section
the term ‘educational curriculum’ means 1 or more of the
following—

“(1) classroom education;

“(2) clinical work experience; and

“(3) continuing education workshops.

“SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY
EDUCATION PROGRAMS.

“(a) STUDY; LIST.—The Secretary, acting through
the Service, and the Secretary of the Interior, in consulta­
tion with Indian Tribes and Tribal Organizations, shall
conduct a study and compile a list of the types of staff
positions specified in subsection (b) whose qualifications
include, or should include, training in the identification,
prevention, education, referral, or treatment of mental ill­
ness, or dysfunctional and self destructive behavior.
“(b) POSITIONS.—The positions referred to in subsection (a) are—

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

“(A) elementary and secondary education;

“(B) social services and family and child welfare;

“(C) law enforcement and judicial services;

and

“(D) alcohol and substance abuse;

“(2) staff positions within the Service; and

“(3) staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations, (without regard to the funding source) and Urban Indian Organizations.

“(c) TRAINING CRITERIA.—

“(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3),
the respective Secretaries shall provide appropriate
training to, or provide funds to, an Indian Tribe,
Tribal Organization, or Urban Indian Organization
for training of appropriate individuals. In the case of
positions funded under a funding agreement, the ap­
propriate Secretary shall ensure that funds to cover
the costs of such training costs are included in the
funding agreement.

“(2) POSITION SPECIFIC TRAINING CRITERIA.—
Position specific training criteria shall be culturally
relevant to Indians and Indian Tribes and shall en­
sure that appropriate information regarding Tradi­
tional Health Care Practices is provided.

“(d) COMMUNITY EDUCATION ON MENTAL ILL­
NESS.—The Service shall develop and implement, on re­
quest of an Indian Tribe or Tribal Organization, or assist
the Indian Tribe or Tribal Organization to develop and
implement a program of community education on mental
illness. In carrying out this subsection, the Service shall,
upon request of an Indian Tribe or Tribal Organization,
provide technical assistance to the Indian Tribe or Tribal
Organization to obtain and develop community edu­
cational materials on the identification, prevention, refer­
ral, and treatment of mental illness and dysfunctional and
self-destructive behavior.
“(e) PLAN.—Not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within 5 years after the date of the enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13, popularly known as the Snyder Act).

“SEC. 128. DESIGNATION OF SHORTAGE AREAS.

“A Service Area served by an Indian Health Program or Urban Indian Organization shall be designated under the Public Health Services Act (42 U.S.C. 250 et seq.) as a shortage area immediately upon request of an Indian Health Program without further evaluation by the Secretary.

“SEC. 129. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.
“TITLE II—HEALTH SERVICES

“SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

“(a) USE OF FUNDS.—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, which are appropriated under the authority of this section, for the purposes of—

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

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

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

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

“(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian Tribes with the highest levels of health status deficiencies and resource deficiencies:

“(A) Clinical care, including, but not limited to, inpatient care, outpatient care (including audiology, clinical eye, and vision care), pri-
mary care, secondary and tertiary care, and
long-term care.

“(B) Preventive health, including mam-
mography and other cancer screening in accord-
ance with section 207.

“(C) Dental care.

“(D) Mental health, including community
mental health services, inpatient mental health
services, dormitory mental health services,
therapeutic and residential treatment centers,
and training of traditional health care practi-
tioners.

“(E) Emergency medical services.

“(F) Treatment and control of, and reha-
bilitative care related to, alcoholism and drug
abuse (including fetal alcohol syndrome) among
Indians.

“(G) Accident prevention programs.

“(H) Home health care.

“(I) Community health representatives.

“(J) Maintenance and repair.

“(K) Traditional Health Care Practices.

“(b) NO OFFSET OR LIMITATION.—Any funds appro-
priated under the authority of this section shall not be
used to offset or limit any other appropriations made to
the Service under this Act or the Act of November 2, 1921
(25 U.S.C. 13, popularly known as the Snyder Act), or
any other provision of law.

“(c) ALLOCATION; USE.—

“(1) IN GENERAL.—Funds appropriated under
the authority of this section shall be allocated to
Service Units, Indian Tribes, or Tribal Organiza-
tions. The funds allocated to each Indian Tribe,
Tribal Organization, or Service Unit under this
paragraph shall be used by the Indian Tribe, Tribal
Organization, or Service Unit under this paragraph
to improve the health status and reduce the resource
deficiency of each Indian Tribe served by such Serv-
vice Unit, Indian Tribe, or Tribal Organization.

“(2) APPORTIONMENT OF ALLOCATED
FUNDS.—The apportionment of funds allocated to a
Service Unit, Indian Tribe, or Tribal Organization
under paragraph (1) among the health service re-

ponsibilities described in subsection (a)(5) shall be
determined by the Service in consultation with, and
with the active participation of, the affected Indian
Tribes and Tribal Organizations.

“(d) PROVISIONS RELATING TO HEALTH STATUS
AND RESOURCE DEFICIENCIES.—For the purposes of this
section, the following definitions apply:
“(1) DEFINITION.—The term ‘health status and resource deficiency’ means the extent to which—

“(A) the health status objectives set forth in section 3(2) are not being achieved; and

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

“(2) AVAILABLE RESOURCES.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

“(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian Tribe or Tribal Organization to petition the Secretary for a review of any determination of the extent of the health status and re-
source deficiency of such Indian Tribe or Tribal Or-
organization.

“(e) ELIGIBILITY FOR FUNDS.—Tribal Health Pro-
grams shall be eligible for funds appropriated under the
authority of this section on an equal basis with programs
that are administered directly by the Service.

“(f) REPORT.—By no later than the date that is 3
years after the date of the enactment of the Indian Health
Care Improvement Act Amendments of 2003, the Sec-
etary shall submit to Congress the current health status
and resource deficiency report of the Service for each
Service Unit, including newly recognized or acknowledged
Indian Tribes. Such report shall set out—

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

“(2) the extent of the health status and re-
source deficiency of each Indian Tribe served by the
Service or a Tribal Health Program;

“(3) the amount of funds necessary to eliminate
the health status and resource deficiencies of all In-
dian Tribes served by the Service or a Tribal Health
Program; and

“(4) an estimate of—
“(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service for the preceding fiscal year which is allocated to each Service Unit, Indian Tribe, or Tribal Organization;

“(B) the number of Indians eligible for health services in each Service Unit or Indian Tribe or Tribal Organization; and

“(C) the number of Indians using the Service resources made available to each Service Unit, Indian Tribe or Tribal Organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

“(g) INCLUSION IN BASE BUDGET.—Funds appropriated under this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

“(h) CLARIFICATION.—Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs, nor are the provisions of this section intended to
discourage the Service from undertaking additional efforts
to achieve equity among Indian Tribes and Tribal Organi-
zations.

“(i) Funding Designation.—Any funds appro-
priated under the authority of this section shall be des-
ignated as the ‘Indian Health Care Improvement Fund’.

“SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

“(a) Establishment.—There is hereby established
an Indian Catastrophic Health Emergency Fund (here-
after in this section referred to as the ‘CHEF’) consisting
of—

“(1) the amounts deposited under subsection
(f); and

“(2) the amounts appropriated to CHEF under
this section.

“(b) Administration.—CHEF shall be adminis-
tered by the Secretary, acting through the central office
of the Service, solely for the purpose of meeting the ex-
traordinary medical costs associated with the treatment of
victims of disasters or catastrophic illnesses who are with-
in the responsibility of the Service.

“(c) Conditions on Use of Fund.—No part of
CHEF or its administration shall be subject to contract
or grant under any law, including the Indian Self-Deter-
mination Act, nor shall CHEF funds be allocated, appor-
tioned, or delegated on an Area Office, Service Unit, or other similar basis.

“(d) REGULATIONS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section to—

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

“(2) provide that a Service Unit shall not be eligible for reimbursement for the cost of treatment from CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

“(A) the 2000 level of $19,000; and

“(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year; and
“(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

“(A) Service Units; or

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

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

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

“(e) NO OFFSET OR LIMITATION.—Amounts appropriated to CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13, popularly known as the Snyder Act), or any other law.

“(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There shall be deposited into 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 cata-
strophic illness the cost of which was paid from CHEF.

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

“(a) FINDINGS.—Congress finds that health pro-
motion and disease prevention activities—

“(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, act-
ing through the Service and Tribal Health Programs, shall
provide health promotion and disease prevention services
to Indians to achieve the health status objectives set forth
in section 3(2).

“(c) EVALUATION.—The Secretary, after obtaining
input from the affected Tribal Health Programs, shall
submit to the President for inclusion in each report which
is required to be submitted to Congress under section 801
an evaluation of—

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

“(2) the health promotion and disease preven-
tion activities which would best meet such needs;
“(3) the internal capacity of the Service and
Tribal Health Programs to meet such needs; and
“(4) the resources which would be required to
enable the Service and Tribal Health Programs to
undertake the health promotion and disease preven-
tion activities necessary to meet such needs.

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

“(a) DETERMINATIONS REGARDING DIABETES.—
The Secretary, acting through the Service, and in con-
sultation with Indian Tribes and Tribal Organizations,
shall determine—
“(1) by an Indian Tribe, Tribal Organization,
and by Service Unit, the incidence of, and the types
of complications resulting from, diabetes among In-
dians; and
“(2) based on the determinations made pursu-
ant to paragraph (1), the measures (including pa-
tient education) each Service Unit should take to re-
duce the incidence of, and prevent, treat, and control
the complications resulting from, diabetes among In-
dian Tribes within that Service Unit.
“(b) DIABETES SCREENING.—To the extent medi-
cally indicated and with informed consent, the Secretary
shall screen each Indian who receives services from the
Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by a Tribal Health Program.

“(c) FUNDING FOR DIABETES.—The Secretary shall continue to fund each model diabetes project in existence on the date of the enactment of the Indian Health Amendments Care Improvement Act of 2003, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2003 and for projects which are added and funded thereafter.

“(d) FUNDING FOR DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian Tribes, and Tribal Organizations to establish dialysis programs, including funding to purchase dialysis equipment and provide necessary staffing.

“(e) OTHER DUTIES OF THE SECRETARY.—The Secretary shall, to the extent funding is available—

“(1) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;
“(2) establish in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

“(3) ensure that data collected in each Area Office regarding diabetes and related complications among Indians is disseminated to all other Area Offices.

“SEC. 205. SHARED SERVICES FOR LONG-TERM CARE.

“(a) Funding Agreements for Long-Term Care.—Notwithstanding any other provisions of law, the Secretary, acting through the Service, is authorized to enter into Funding Agreements or other arrangements with Indian Tribes or Tribal Organizations for the delivery of long-term care and similar services to Indians. Such funding agreements or other arrangements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or other similar facility owned and operated (directly or through a Funding Agreement) by such Indian Tribe or Tribal Organization.

“(b) Contents of Funding Agreements.—A Funding Agreement or other arrangement entered into pursuant to subsection (a)—
“(1) may, at the request of the Indian Tribe or Tribal Organization, delegate to such Indian Tribe or Tribal Organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

“(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the Service and the Indian Tribe or Tribal Organization; and

“(3) may authorize such Indian Tribe or Tribal Organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

“(c) MINIMUM REQUIREMENT.—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act.

“(d) OTHER ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.
“(e) Use of Existing or Underused Facilities.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

“SEC. 206. HEALTH SERVICES RESEARCH.

“The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs and shall coordinate the activities of other agencies within the Department to address these research needs. The funding shall be divided equitably among the Area Offices. Then each Area Office shall award the funds competitively within that Area. The Secretary shall consult with Indian Tribes and Tribal Organizations in developing the methodology used to allocate these funds among Area Offices for competitive awards. Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section. This funding may be used for both clinical and nonclinical research.

“SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

“The Secretary, acting through the Service or Tribal Health Programs, shall provide for screening as follows:
“(1) Screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, such as those of the National Cancer Institute for the National Institutes for Health, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

“(2) Other cancer screening meeting national standards, such as those of the National Cancer Institute.

“SEC. 208. PATIENT TRAVEL COSTS.

“The Secretary, acting through the Service and Tribal Health Programs, shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving health care services provided (either through direct or contract care or through Funding Agreements) under this Act—

“(1) emergency air transportation and non-emergency air transportation where ground transportation is infeasible;

“(2) transportation by private vehicle, specially equipped vehicle, and ambulance; and
“(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

“SEC. 209. EPIDEMIOLOGY CENTERS.

“(a) ADDITIONAL CENTERS.—In addition to those epidemiology centers already established at the time of enactment of this Act, (including those for which funding is currently being provided in Funding Agreements), and without reducing the funding levels for such centers, not later than 180 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, shall establish and fund an epidemiology center in each Service Area which does not yet have one to carry out the functions described in subsection (b). Any new centers so established may be operated by Tribal Health Programs, but such funding shall not be divisible.

“(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each Service Area epidemiology center established under this subsection shall, with respect to such Service Area—

“(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes,
Tribal Organizations, and Urban Indian Organizations in the Service Area;

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

“(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

“(4) make recommendations for the targeting of services needed by the populations served;

“(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

“(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

“(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.
“(c) Technical Assistance.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

“(d) Funding for Studies.—The Secretary may make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct epidemiological studies of Indian communities.


“(a) Funding for Development of Programs.—The Secretary, acting through the Service, shall provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and Urban Indian children.

“(b) Use of Funds.—Funding provided under this section may be used for purposes which may include, but are not limited to, the following:

“(1) Developing and implementing health education curricula both for regular school programs and afterschool programs.

“(2) Training teachers in comprehensive school health education curricula.
“(3) Integrating school-based, community-based, and other public and private health promotion efforts.

“(4) Encouraging healthy, tobacco-free school environments.

“(5) Coordinating school-based health programs with existing services and programs available in the community.

“(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

“(7) Developing mental health wellness programs.

“(8) Developing chronic disease prevention programs.

“(9) Developing substance abuse prevention programs.

“(10) Developing injury prevention and safety education programs.

“(11) Developing activities for the prevention and control of communicable diseases.

“(12) Developing community and environmental health education programs that include traditional health care practitioners.

“(13) Violence prevention.
“(14) Such other health issues as are appropriate.

“(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

“(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, and in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications for funding provided pursuant to this section.

“(e) DEVELOPMENT OF PROGRAM FOR BIA FUNDED SCHOOLS.—

“(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary, acting through the Service, and affected Indian Tribes and Tribal Organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.
“(2) Requirements for Programs.—Such programs shall include the following—

“(A) school programs on nutrition education, personal health, oral health, and fitness;
“(B) mental health wellness programs;
“(C) chronic disease prevention programs;
“(D) substance abuse prevention programs;
“(E) injury prevention and safety education programs; and
“(F) activities for the prevention and control of communicable diseases.

“(3) Duties of the Secretary.—The Secretary of the Interior shall—

“(A) provide training to teachers in comprehensive school health education curricula;
“(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and
“(C) encourage healthy, tobacco-free school environments.

“SEC. 211. INDIAN YOUTH PROGRAM.

“(a) Program Authorized.—The Secretary, acting through the Service, is authorized to establish and admin-
ister a program to provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and Urban Indian preadolescent and adolescent youths.

“(b) USE OF FUNDS.—

“(1) ALLOWABLE USES.—Funds made available under this section may be used to—

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

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

“(2) PROHIBITED USE.—Funds made available under this section may not be used to provide services described in section 707(e).

“(c) DUTIES OF THE SECRETARY.—The Secretary shall—

“(1) disseminate to Indian Tribes, Tribal Organizations, and Urban Indian Organizations information regarding models for the delivery of comprehensive health care services to Indian and Urban Indian adolescents;
“(2) encourage the implementation of such models; and

“(3) at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance in the implementation of such models.

“(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organization, and Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

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

“(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, and after consultation with Indian Tribes, Tribal Organizations, Urban Indian Organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian Tribes and Tribal Organizations for the following:

“(1) Projects for the prevention, control, and elimination of communicable and infectious diseases including, but not limited to, tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori.
“(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

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

“(4) Demonstration projects for the screening, treatment, and prevention of hepatitis C virus (HCV).

“(b) APPLICATION REQUIRED.—The Secretary may provide funding under subsection (a) only if an application or proposal for funding is submitted to the Secretary.

“(c) COORDINATION WITH HEALTH AGENCIES.—Indian Tribes and Tribal Organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

“(d) TECHNICAL ASSISTANCE; REPORT.—In carrying out this section, the Secretary—

“(1) may, at the request of an Indian Tribe or Tribal Organization, provide technical assistance; and
“(2) shall prepare and submit a report to Congress biennially on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and Urban Indians.

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

“(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act, which shall include, but not be limited to—

“(1) hospice care and assisted living;

“(2) long-term health care;

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

“(4) public health functions; and

“(5) Traditional Health Care Practices.

“(b) SERVICES TO OTHERWISE INELIGIBLE PERSONS.—At the discretion of the Service, Indian Tribes, or Tribal Organizations, services provided for hospice care, home health care, home- and community-based care, assisted living, and long-term care may be provided (subject to reimbursement of reasonable charges) to persons other-
wise ineligible for the health care benefits of the Service.

Any funds received under this subsection shall not be used
to offset or limit the funding allocated to an Indian Tribe
or Tribal Organization.

“(c) DEFINITIONS.—For the purposes of this section,
the following definitions shall apply:

“(1) The term ‘home- and community-based
services’ means 1 or more of the following:

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

“(B) Chore services.

“(C) Personal care services.

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

“(E) Respite care.

“(F) Training for family members.

“(G) Adult day care.

“(H) Such other home- and community-
based services as the Secretary, an Indian
Tribe, or Tribal Organization may approve.

“(2) The term ‘hospice care’ means the items
and services specified in subparagraphs (A) through
(H) of section 1861(dd)(1) of the Social Security
Act (42 U.S.C. 1395x(dd)(1)), and such other serv-
ices which an Indian Tribe or Tribal Organization
determines are necessary and appropriate to provide
in furtherance of this care.

“(3) The term ‘public health functions’ means
the provision of public health-related programs,
functions, and services including, but not limited to,
asessment, assurance, and policy development which
Indian Tribes and Tribal Organizations are author­
ized and encouraged, in those circumstances where
it meets their needs, to do by forming collaborative
relationships with all levels of local, State, and Fed­
eral Government.

“SEC. 214. INDIAN WOMEN’S HEALTH CARE.
“Sec. 214. INDIAN WOMEN’S HEALTH CARE.

“The Secretary, acting through the Service and In­
dian Tribes, Tribal Organizations, and Urban Indian Or­
ganizations, shall provide funding to monitor and improve
the quality of health care for Indian women of all ages
through the planning and delivery of programs adminis­
tered by the Service, in order to improve and enhance the
treatment models of care for Indian women.

“SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZ­
ARDS.

“(a) STUDIES AND MONITORING.—The Secretary
and the Service shall conduct, in conjunction with other
appropriate Federal agencies and in consultation with con­
cerned Indian Tribes and Tribal Organizations, studies
and ongoing monitoring programs to determine trends in
the health hazards to Indian miners and to Indians on
or near reservations and Indian communities as a result
of environmental hazards which may result in chronic or
life threatening health problems, such as nuclear resource
development, petroleum contamination, and contamination
of water source and of the food chain. Such studies shall
include—

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

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

“(3) an evaluation of the types and nature of
activities, practices, and conditions causing or affect-
ing such health problems including, but not limited
to, uranium mining and milling, uranium mine tail-
ing deposits, nuclear power plant operation and con-
struction, and nuclear waste disposal; oil and gas
production or transportation on or near reservations
or Indian communities; and other development that
could affect the health of Indians and their water
supply and food chain;

“(4) a summary of any findings and rec-
ommendations provided in Federal and State stud-
ies, reports, investigations, and inspections during
the 5 years prior to the date of the enactment of the
Indian Health Care Improvement Act Amendments
of 2003 that directly or indirectly relate to the ac-
tivities, practices, and conditions affecting the health
or safety of such Indians; and

“(5) the efforts that have been made by Federal
and State agencies and resource and economic devel-
opment companies to effectively carry out an edu-
cation program for such Indians regarding the
health and safety hazards of such development.

“(b) HEALTH CARE PLANS.—Upon completion of
such studies, the Secretary and the Service shall take into
account the results of such studies and, in consultation
with Indian Tribes and Tribal Organizations, develop
health care plans to address the health problems studied
under subsection (a). The plans shall include—

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

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

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

“(c) Submission of Report and Plan to Congress.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003. The health care plan prepared under subsection (b) shall be submitted in a report no later than 1 year after the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address such health problems.

“(d) Intergovernmental Task Force.—

“(1) Establishment; Members.—There is established an Intergovernmental Task Force to be
composed of the following individuals (or their designees):

“(A) The Secretary of Energy.
“(B) The Secretary of the Environmental Protection Agency.
“(C) The Director of the Bureau of Mines.
“(D) The Assistant Secretary for Occupational Safety and Health.
“(E) The Secretary of the Interior.
“(F) The Secretary of Health and Human Services.
“(G) The Director of the Indian Health Service.

“(2) DUTIES.—The Task Force shall—

“(A) identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near a reservation or in an Indian community; and

“(B) enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.
“(3) CHAIRMAN; MEETINGS.—The Secretary of Health and Human Services shall be the Chairman of the Task Force. The Task Force shall meet at least twice each year.

“(e) HEALTH SERVICES TO CERTAIN EMPLOYEES.—

In the case of any Indian who—

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

“(2) is eligible to receive diagnosis and treatment services from an Indian Health Program; and

“(3) by reason of such Indian’s employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard, the Indian Health Program shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may be reimbursed for any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such amounts paid to the Indian Health Program
from the employer for providing medical care for
such illness or condition.

“SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DE-
LIVERY AREA.
“(a) In General.—For fiscal years beginning with
the fiscal year ending September 30, 1983, and ending
with the fiscal year ending September 30, 2015, the State
of Arizona shall be designated as a contract health service
delivery area by the Service for the purpose of providing
contract health care services to members of federally rec-
ognized Indian Tribes of Arizona.
“(b) Maintenance of Services.—The Service
shall not curtail any health care services provided to Indi-
ans residing on reservations in the State of Arizona if such
curtailment is due to the provision of contract services in
such State pursuant to the designation of such State as
a contract health service delivery area pursuant to sub-
section (a).

“SEC. 216A. NORTH DAKOTA AS A CONTRACT HEALTH
SERVICE DELIVERY AREA.
“(a) In General.—For fiscal years beginning with
the fiscal year ending September 30, 2003, and ending
with the fiscal year ending September 30, 2015, the State
of North Dakota shall be designated as a contract health
service delivery area by the Service for the purpose of pro-
viding contract health care services to members of federally recognized Indian Tribes of North Dakota.

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

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

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

“(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on reservations in the State of South Dakota if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a contract health service delivery area pursuant to subsection (a).
SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES PROGRAM.

(a) Funding Authorized.—The Secretary is authorized to fund a program using the California Rural Indian Health Board (hereafter in this section referred to as the ‘CRIHB’) as a contract care intermediary to improve the accessibility of health services to California Indians.

(b) Reimbursement Contract.—The Secretary shall enter into an agreement with the CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

(c) Administrative Expenses.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB during such fiscal year.

(d) Limitation on Payment.—No payment may be made for treatment provided hereunder to the extent payment may be made for such treatment under the Indian Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise
made available to the California contract health service delivery area for a fiscal year.

“(e) ADVISORY BOARD.—There is hereby established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least one half of whom of whom are not affiliated with the CRIHB.

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

“The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to California Indians. However, any of the counties listed herein may only be included in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.
“SEC. 219. CONTRACT HEALTH SERVICES FOR THE TREN­TTON SERVICE AREA.

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

“(b) NO EXPANSION OF ELIGIBILITY.—Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

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

“The Service shall provide funds for health care pro­grams and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

“SEC. 221. LICENSING.

“Health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the

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Tribal Health Program performs the services described in its Funding Agreement.

“SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.

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

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

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

“(b) EFFECT OF UNTIMELY RESPONSE.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

“(c) DEADLINE FOR PAYMENT OF VALID CLAIM.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.
“SEC. 224. LIABILITY FOR PAYMENT.

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

“(b) Notification.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

“(c) No Recourse.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall have no further recourse against the patient who received the services.

“SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out this title.
“TITLE III—FACILITIES

“SEC. 301. CONSULTATION; CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

“(a) Prerequisites for Expenditure of Funds.—Prior to the expenditure of, or the making of any binding commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall—

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

“(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any accrediting body recognized by the Secretary for the purposes of the medicare, medicaid, and SCHIP programs under title XVIII, XIX, and XXI of the Social Security Act by not later than 1 year after the date on which the construction or renovation of such facility is completed.

“(b) Closures.—
“(1) Evaluation Required.—Notwithstanding any other provision of law, no facility operated by the Service may be closed if the Secretary has not submitted to Congress at least 1 year prior to the date of the proposed closure an evaluation of the impact of the proposed closure which specifies, in addition to other considerations the following:

“(A) The accessibility of alternative health care resources for the population served by such facility.

“(B) The cost-effectiveness of such closure.

“(C) The quality of health care to be provided to the population served by such facility after such closure.

“(D) The availability of contract health care funds to maintain existing levels of service.

“(E) The views of the Indian Tribes served by such facility concerning such closure.

“(F) The level of use of such facility by all eligible Indians.

“(G) The distance between such facility and the nearest operating Service hospital.

“(2) Exception for Certain Temporary Closures.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a
facility if such closure is necessary for medical, environ­
mental, or construction safety reasons.

“(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

“(1) IN GENERAL.—

“(A) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a health care facility priority system, which shall—

“(i) be developed with Indian Tribes and Tribal Organizations through negotiated rulemaking under section 802;

“(ii) give Indian Tribes’ needs the highest priority; and

“(iii) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E).

“(B) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of the Indian Health Care Improvement Act Amendments of 2003 shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as 1 of the 10 top-priority inpatient projects, 1 of the 10 top-pri-
ority outpatient projects, 1 of the 10 top-pri-

ority staff quarters developments, or 1 of the
10 top-priority Youth Regional Treatment Cen-
ters in the fiscal year 2004 Indian Health Serv-
ce budget justification, or if the project had
completed both Phase I and Phase II of the
construction priority system in effect on the
date of the enactment of such Act.

“(2) REPORT; CONTENTS.—The Secretary shall
submit to the President, for inclusion in each report
required to be transmitted to Congress under section
801, a report which sets forth the following:

“(A) A description of the health care facil-
ity priority system of the Service, established
under paragraph (1).

“(B) Health care facilities lists, including
but not limited to—

“(i) the total health care facilities
planning, design, construction, and renova-
tion needs for Indians, identified by na-
tional and Service Area priorities;

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

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

“(v) the 10 top-priority staff quarters developments associated with health care facilities; and

“(vi) the 10 top-priority hostels associated with health care facilities.

“(C) The justification for such order of priority.

“(D) The projected cost of such projects.

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

“(3) REQUIREMENTS FOR PREPARATION OF REPORTS.—In preparing each report required under paragraph (2) (other than the initial report), the Secretary shall annually—

“(A) consult with and obtain information on all health care facilities needs from Indian Tribes, Tribal Organizations, and Urban Indian Organizations; and

“(B) review the total unmet needs of all Indian Tribes and Tribal Organizations for
health care facilities (including hostels and staff
quarters), including needs for renovation and
expansion of existing facilities.

“(4) CRITERIA FOR EVALUATING NEEDS.—For
purposes of this subsection, the Secretary shall, in
evaluating the needs of facilities operated under any
Funding Agreement use the same criteria that the
Secretary uses in evaluating the needs of facilities
operated directly by the Service.

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

“(d) REVIEW OF NEED FOR FACILITIES.—

“(1) INITIAL REPORT.—In the year 2005, the
General Accounting Office shall prepare and finalize
a report which sets forth the needs of the Service,
Indian Tribes, Tribal Organizations, and Urban In-
dian Organizations, for the facilities listed under
subsection (c)(2)(B), including the needs for renova-
tion and expansion of existing facilities. The General
Accounting Office shall submit the report to the appropriate authorizing and appropriations committees of the Congress and to the Secretary.

“(2) Beginning in the year 2006, the Secretary shall annually update the report required under paragraph (1).

“(3) The Comptroller General and the Secretary shall consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations. In preparing the reports required by paragraphs (1) and (2), the Secretary shall submit the report to the President for inclusion in the report required to be transmitted to the Congress under section 801.

“(4) For purposes of this subsection, the reports shall, regarding the needs of facilities operated under any Funding Agreement be based on the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

“(5) The planning, design, construction, and renovation needs of facilities operated under Funding Agreements shall be fully and equitably integrated into the development of the health facility priority system.

“(6) Beginning in the year 2006 and each fiscal year thereafter, the Secretary shall provide an op-
portunity for nomination of planning, design, and
construction projects by the Service, Indian Tribes,
and Tribal Organizations for consideration under
the health care facility priority system.

“(e) FUNDING CONDITION.—All funds appropriated
under the Act of November 2, 1921 (25 U.S.C. 13), for
the planning, design, construction, or renovation of health
facilities for the benefit of 1 or more Indian Tribes shall
be subject to the provisions of the Indian Self-Determina-
tion and Education Assistance Act.

“(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—
The Secretary shall consult and cooperate with Indian
Tribes, Tribal Organizations, and Urban Indian Organiza-
tions in developing innovative approaches to address all
or part of the total unmet need for construction of health
facilities, including those provided for in other sections of
this title and other approaches.

“SEC. 302. SANITATION FACILITIES.

“(a) FINDINGS.—Congress finds the following:

“(1) The provision of sanitation facilities is pri-
marily a health consideration and function.

“(2) Indian people suffer an inordinately high
incidence of disease, injury, and illness directly at-
tributable to the absence or inadequacy of sanitation
facilities.
“(3) The long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing sanitation facilities and other preventive health measures.

“(4) Many Indian homes and Indian communities still lack sanitation facilities.

“(5) It is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with sanitation facilities.

“(b) FACILITIES AND SERVICES.—In furtherance of the findings made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a). Under such authority, the Secretary, acting through the Service, shall provide the following:

“(1) Financial and technical assistance to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of
the Indian Tribe, Tribal Organization, or Indian community.

“(2) Ongoing technical assistance and training to Indian Tribes, Tribal Organizations, and Indian communities in the management of utility organizations which operate and maintain sanitation facilities.

“(3) Priority funding for operation and maintenance assistance for, and emergency repairs to, sanitation facilities operated by an Indian Tribe, Tribal Organization or Indian community when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

“(c) FUNDING.—Notwithstanding any other provision of law—

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

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

“(3) unless specifically authorized otherwise
when funds are appropriated, the Secretary of
Health and Human Services shall use funds appro­
priated under section 7 of the Act of August 5, 1954
(42 U.S.C. 2004a), to provide additional priority of
sanitation facilities assistance to eligible new and ex­
isting Indian homes other than the following—

“(A) new homes constructed using housing
funds provided by the Department of Housing
and Urban Development; and

“(B) existing homes owned or managed by
a tribally designated housing entity (as that
term is defined in section 4(21) of the Native
American Housing Assistance and Self-Deter­
mination Act of 1996 (25 U.S.C. 4103(21))
that were constructed using housing funds pro­
vided by the Department of Housing and Urban
Development;

“(4) the Secretary of Health and Human Serv­
cices is authorized to accept from any source, includ­
ing Federal and State agencies, funds for the pur­
pose of providing sanitation facilities and services
and place these funds into Funding Agreements;
“(5) funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) may be used to fund up to 100 percent of the amount of an Indian Tribe’s loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

“(6) funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) may be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

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

“(8) the Secretary of Health and Human Services shall enter into interagency agreements with Federal and State agencies for the purpose of providing financial assistance for sanitation facilities and services under this Act; and

“(9) the Secretary of Health and Human Services shall, by regulation developed through rule-making under section 802, establish standards appli-
cable to the planning, design, and construction of sanitation facilities funded under this Act.

“(d) Funding Plan.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall develop and begin implementation of a 10-year funding plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.

“(e) Certain Capabilities Not Prerequisite.—The financial and technical capability of an Indian Tribe, Tribal Organization, or Indian community to safely operate, manage, and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

“(f) Financial Assistance.—The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities for operation, management, and maintenance of their sanitation facilities.

“(g) Operation, Management, and Maintenance of Facilities.—The Indian Tribe, Tribal Organization, Indian family, or Indian community has the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating, managing, and maintaining sanitation facilities.
If a sanitation facility serving a community that is operated by an Indian Tribe, Tribal Organization, or Indian community is threatened with imminent failure and such operator lacks capacity to maintain the integrity or the health benefits of the sanitation facility, then the Secretary is authorized to assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

(h) ISDEAA Program Funded on Equal Basis.—Tribal Health Programs shall be eligible (on an equal basis with programs that are administered directly by the Service) for—

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

“(2) any funds appropriated for the purpose of providing sanitation facilities.

(i) Report.—

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

“(A) the current Indian sanitation facility priority system of the Service;
“(B) the methodology for determining sanitation deficiencies;

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

“(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (4)(A).

“(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall consult with Indian Tribes and Tribal Organizations to determine the sanitation facility needs of each Indian Tribe. The criteria on which the needs will be evaluated shall be developed through negotiated rule-making pursuant to section 802.

“(3) UNIFORM METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for, and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian Tribes and Indian communities.
“(4) Sanitation deficiency levels.—For purposes of this subsection, the sanitation deficiency levels for an individual, Indian Tribe or Indian community sanitation facility to serve Indian homes are determined as follows:

“(A) A level I deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community—

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

“(ii) deficiencies relate to routine replacement, repair, or maintenance needs.

“(B) A level II deficiency exists if a sanitation facility serving an individual, Indian Tribe, or Indian community substantially or recently complied with all applicable water supply, pollution control, and solid waste laws and any deficiencies relate to—

“(i) small or minor capital improvements needed to bring the facility back into compliance;

“(ii) capital improvements that are necessary to enlarge or improve the facili-
ties in order to meet the current needs for
domestic sanitation facilities; or

“(iii) the lack of equipment or train-
ing by an Indian Tribe, Tribal Organiza-
tion, or an Indian community to properly
operate and maintain the sanitation facili-
ties.

“(C) A level III deficiency exists if a sani-
tation facility serving an individual, Indian
Tribe or Indian community meets one or more
of the following conditions—

“(i) water or sewer service in the
home is provided by a haul system with
holding tanks and interior plumbing;

“(ii) major significant interruptions to
water supply or sewage disposal occur fre-
quently, requiring major capital improve-
ments to correct the deficiencies; or

“(iii) there is no access to or no ap-
proved or permitted solid waste facility
available.

“(D) A level IV deficiency exists if—

“(i) a sanitation facility of an indi-
vidual, Indian Tribe, Tribal Organization,
or Indian community has no piped water
or sewer facilities in the home or the facility has become inoperable due to major component failure; or

“(ii) where only a washeteria or central facility exists in the community.

“(E) A level V deficiency exists in the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater (including sewage) disposal.

“(j) DEFINITIONS.—For purposes of this section, the following terms apply:

“(1) INDIAN COMMUNITY.—The term ‘Indian community’ means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

“(2) SANITATION FACILITIES.—The terms ‘sanitation facility’ and ‘sanitation facilities’ mean safe and adequate water supply systems, sanitary sewage disposal systems, and sanitary solid waste systems (and all related equipment and support infrastructure).
“SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

“(a) Buy Indian Act.—The Secretary, acting through the Service, may use the negotiating authority of section 23 of the Act of June 25, 1910 (25 U.S.C. 47, commonly known as the ‘Buy Indian Act’), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian Tribes in the State of New York (hereinafter referred to as an ‘Indian firm’) in the construction and renovation of Service facilities pursuant to section 301 and in the construction of sanitation facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to regulations adopted pursuant to section 802, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such a finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

“(1) ownership and control by Indians;

“(2) equipment;

“(3) bookkeeping and accounting procedures;

“(4) substantive knowledge of the project or function to be contracted for;
“(5) adequately trained personnel; or

“(6) other necessary components of contract performance.

“(b) LABOR STANDARDS.—

“(1) IN GENERAL.—For the purposes of implementing the provisions of this title, contracts for the construction or renovation of health care facilities, staff quarters, and sanitation facilities, and related support infrastructure, funded in whole or in part with funds made available pursuant to this title, shall contain a provision requiring compliance with the Act of March 3, 1931 (40 U.S.C. 276a—276a—5, known as the Davis-Bacon Act), unless such construction or renovation—

“(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract, compact or funding agreement authorized by the Indian Self-Determination and Education Assistance Act, or other statutory authority; and

“(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal
Organizations to be served by the construction or renovation.

“(2) Exception.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

“SEC. 304. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

“(a) In General.—Notwithstanding any other provision of law, if the requirements of subsection (c) are met, the Secretary, acting through the Service, is authorized to accept any major expansion, renovation, or modernization by any Indian Tribe or Tribal Organization of any Service facility or of any other Indian health facility operated pursuant to a Funding Agreement, including—

“(1) any plans or designs for such expansion, renovation, or modernization; and

“(2) any expansion, renovation, or modernization for which funds appropriated under any Federal law were lawfully expended.

“(b) Priority List.—

“(1) In General.—The Secretary shall maintain a separate priority list to address the needs for increased operating expenses, personnel, or equipment for such facilities. The methodology for estab-
lishing priorities shall be developed through negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian Tribes and Tribal Organizations.

“(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to Congress under section 801, the priority list maintained pursuant to paragraph (1).

“(c) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation, or modernization if—

“(1) the Indian Tribe or Tribal Organization—

“(A) provides notice to the Secretary of its intent to expand, renovate, or modernize; and

“(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel, or equipment; and

“(2) the expansion, renovation, or modernization—

“(A) is approved by the appropriate area director of the Service for Federal facilities; and

“(B) is administered by the Indian Tribe or Tribal Organization in accordance with any applicable regulations prescribed by the Sec-
retary with respect to construction or renovation of Service facilities.

“(d) CLOSURE OR CONVERSION OF FACILITIES.—If any Service facility which has been expanded, renovated, or modernized by an Indian Tribe or Tribal Organization under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation, or modernization is completed, such Indian Tribe or Tribal Organization shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation, or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation, or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

“SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

“(a) Funding.—

“(1) In general.—The Secretary, acting through the Service, in consultation with Indian Tribes and Tribal Organizations, shall make funding
available to Indian Tribes and Tribal Organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons pursuant to subsections (b)(2) and (c)(1)(C)). Funding made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term ‘construction’ includes the replacement of an existing facility.

“(2) FUNDING AGREEMENT REQUIRED.—Funding under paragraph (1) may only be made available to a Tribal Health Program operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian Tribe or Tribal Organization).

“(b) USE OF FUNDS.—

“(1) ALLOWABLE USES.—Funding provided under this section may be used only for debt reduction or the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

“(A) located apart from a hospital;
“(B) not funded under section 301 or section 307; and

“(C) which, upon completion of such construction or modernization will—

“(i) have a total capacity appropriate to its projected service population;

“(ii) provide annually no fewer than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(c)(2); and

“(iii) provide ambulatory care in a Service Area (specified in the Funding Agreement) with a population of no fewer than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(c)(2).

“(2) USE ONLY FOR CERTAIN PORTION OF COSTS.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion, or modernization project that benefits the Service population identified above in subsection (b)(1)(C)(ii) and (iii). The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to an Indian Tribe or Tribal Organization ap-
plying for funding under this section whose principal office for health care administration is located on an island or when such office is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

“(c) FUNDING.—

“(1) APPLICATION.—No funding may be made available under this section unless an application or proposal for such funding has been approved by the Secretary in accordance with applicable regulations and has forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section—

“(A) adequate financial support will be available for the provision of services at such facility;

“(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

“(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.
“(2) PRIORITY.—In awarding funding under this section, the Secretary shall give priority to Indian Tribes and Tribal Organizations that demonstrate—

“(A) a need for increased ambulatory care services; and

“(B) insufficient capacity to deliver such services.

“(3) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and proposals and to advise the Secretary regarding such applications using the criteria developed during consultations pursuant to subsection (a)(1).

“(d) REVERSION OF FACILITIES.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be used for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian Tribe or Tribal Organization.
“(e) FUNDING NONRECURRING.—Funding provided under this section shall be nonrecurring and shall not be available for inclusion in any individual Indian Tribe’s tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

“SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

“(a) HEALTH CARE DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, is authorized to enter into Funding Agreements with, or make grants or loan guarantees to, Indian Tribes or Tribal Organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services to Indians through facilities, including but not limited to hospice, traditional Indian health, and child care facilities.

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

“(1) waive any leasing prohibition;
“(2) permit carryover of funds appropriated for the provision of health care services;

“(3) permit the use of other available funds;

“(4) permit the use of funds or property donated from any source for project purposes;

“(5) provide for the reversion of donated real or personal property to the donor; and

“(6) permit the use of Service funds to match other funds, including Federal funds.

“(c) REGULATIONS.—The Secretary shall develop and publish regulations, through rulemaking under section 802, for the review and approval of applications submitted under this section.

“(d) CRITERIA.—The Secretary may enter into a contract or Funding Agreement or award a grant under this section for projects which meet the following criteria:

“(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

“(2) A significant number of Indians, including those with low health status, will be served by the project.

“(3) The project has the potential to deliver services in an efficient and effective manner.

“(4) The project is economically viable.
“(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

“(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

“(e) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria developed pursuant to subsection (d).

“(f) PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Units to the extent that such applications are timely filed and meet the criteria specified in subsection (d):

“(1) Cass Lake, Minnesota.

“(2) Clinton, Oklahoma.

“(3) Harlem, Montana.

“(4) Mescalero, New Mexico.

“(5) Owyhee, Nevada.

“(6) Parker, Arizona.

“(7) Schurz, Nevada.

“(8) Winnebago, Nebraska.

“(9) Ft. Yuma, California.
“(g) **Technical Assistance.**—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

“(h) **Service to Ineligible Persons.**—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

“(i) **Equitable Treatment.**—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any Funding Agreement, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

“(j) **Equitable Integration of Facilities.**—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities which are the subject of a Funding Agreement for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.
"SEC. 307. LAND TRANSFER."

“(a) CHEMAWA INDIAN SCHOOL.—The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.

“(b) FEDERAL LAND TO THE SERVICE.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

"SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS."

“The Secretary, acting through the Service, may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or ren-
ovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination Act and regulations thereunder. Notwithstanding any other provision of law, such leases, contracts, or other agreements shall be considered as operating leases for the purpose of scoring under the Budget Enforcement Act.

"SEC. 309. LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.

“(a) Establishment of Fund.—There is established in the Treasury of the United States a fund to be known as the Health Care Facilities Loan Fund (hereinafter referred to as the ‘HCFLF’) to provide to Indian Tribes and Tribal Organizations direct loans, or guarantees for loans, for construction of health care facilities (including but not limited to inpatient facilities, outpatient facilities, staff quarters, hostels, and specialized care facilities such as behavioral health and elder care facilities).

“(b) Regulations; Standards and Procedures.—The Secretary, acting through the Service, is authorized to issue regulations, developed through rulemaking as set out in section 802, to provide standards and procedures for governing such loans and loan guarantees, subject to the following conditions:
“(1) The principal amount of a loan or loan guarantee may cover 100 percent of eligible costs, including but not limited to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, other facility-related costs and capital purchase (but excluding staffing).

“(2) The cumulative total of the principal of direct loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

“(3) In the discretion of the Secretary, the program may be administered by the Service or the Health Resources and Services Administration (which shall be specified by regulation).

“(4) The Secretary may make or guarantee a loan with a term of the useful estimated life of the facility, or 25 years, whichever is shorter.

“(5) The Secretary may allocate up to 100 percent of the funds available for loans or loan guarantees in any year for the purpose of planning and applying for a loan or loan guarantee.

“(6) The Secretary may accept an assignment of the revenue of an Indian Tribe or Tribal Organi-
zation as security for any direct loan or loan guar­
antee under this section.

“(7) In the planning and design of health facili­
ties under this section, users eligible under section
807(c) may be included in any projection of patient
population.

“(8) The Secretary shall not collect loan appli­
cation, processing, or other similar fees from Indian
Tribes or Tribal Organizations applying for direct
loans or loan guarantees under this section.

“(9) Service funds authorized under loans or
loan guarantees in this section shall be eligible for
use in matching other Federal funds.

“(c) AMOUNT FOR HCFLF.—

“(1) IN GENERAL.—The HCFLF shall consist
of—

“(A) such sums as may be initially appro­
priated to the HCFLF and as may be subse­
quently appropriated to the fund under para­
graph (2);

“(B) such amounts as may be collected
from borrowers; and

“(C) all interest earned on amounts in the
HCFLF.
“(2) Initial Funds.—There are authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the HCFLF during the preceding fiscal year and all accrued interest.

“(3) Available Until Expended.—All amounts appropriated, collected, or earned relative to the HCFLF shall remain available until expended.

“(4) Investments.—The Secretary of the Treasury shall invest such amounts of the HCFLF as such Secretary determines are not required to meet current withdrawals from the HCFLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at the market price. Any obligation acquired by the fund may be sold by the Secretary of the Treasury at the market price.

“(d) Loans Under ISDEAA.—Amounts in the HCFLF and available pursuant to appropriation Acts may
be expended by the Secretary to make loans under this section to a Tribal Health Program.

“(e) GRANTS TO REPAY LOANS.—The Secretary is authorized to establish a program to provide grants to Indian Tribes and Tribal Organizations for the purpose of repaying all or part of any loan obtained by an Indian Tribe or Tribal Organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, small ambulatory care, staff quarters, and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

“SEC. 310. TRIBAL LEASING.

“A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

“SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

“(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease,
in exchange for agreement by the Service to provide the
equipment, supplies, and staffing for the operation and
maintenance of such a health facility. An Indian Tribe or
Tribal Organization may use tribal funds, private sector,
or other available resources, including loan guarantees, to
fulfill its commitment under a joint venture entered into
under this subsection. An Indian Tribe or Tribal Organi-
zation shall be eligible to establish a joint venture project
if, when it submits a letter of intent, it—

“(1) has begun but not completed the process
of acquisition or construction of a health facility to
be used in the joint venture project; or

“(2) has not begun the process of acquisition or
construction of a health facility for use in the joint
venture project.

“(b) REQUIREMENTS.—The Secretary shall make
such an arrangement with an Indian Tribe or Tribal Orga-
nization only if—

“(1) the Secretary first determines that the In-
dian Tribe or Tribal Organization has the adminis-
trative and financial capabilities necessary to com-
plete the timely acquisition or construction of the
relevant health facility; and

“(2) the Indian Tribe or Tribal Organization
meets the need criteria which shall be developed
through the negotiated rulemaking process provided for under section 802.

“(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization regarding the continued operation of the facility at the end of the initial 10 year no-cost lease period.

“(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe’s or Tribal Organization’s behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

“(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this subsection shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time
within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agree-
ment.

“(f) DEFINITION.—For the purposes of this section, the term ‘health facility’ or ‘health facilities’ includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

“SEC. 312. LOCATION OF FACILITIES.

“(a) IN GENERAL.—In all matters involving the reorganiza-
tion or development of Service facilities or in the establish-
ment of related employment projects to address unemploy-
ment conditions in economically depressed areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

“(b) DEFINITION.—For purposes of this section, the term ‘Indian lands’ means—

“(1) all lands within the exterior boundaries of any reservation;

“(2) any lands title to which is held in trust by the United States for the benefit of any Indian
Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian Tribe exercises governmental power; and “(3) all lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

**SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.**

“(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

“(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization.
Supportable space allocation shall be defined through the negotiated rulemaking process provided for under section 802.

“(c) Replacement Facilities.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

“SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

“(a) Rental Rates.—

“(1) Establishment.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a Funding Agreement shall have the authority to establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.
“(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

“(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

“(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserve funds for capital repairs and replacement of the quarters.

“(3) EQUITABLE FUNDING.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

“(4) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided under this subsection shall provide occupants with no less than 60 days notice of any change in rental rates.
“(b) Direct Collection of Rent.—

“(1) In General.—Notwithstanding any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

“(A) The Tribal Health Program shall notify the Secretary and the subject Federal employees of its election to exercise its authority to collect rents directly from such Federal employees.

“(B) Upon receipt of a notice described in subparagraph (A), the Federal employees shall pay rents for occupancy of such quarters directly to the Tribal Health Program and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

“(C) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

“(D) Such rent payments shall be deposited into a separate account which shall be used by the Tribal Health Program for the mainte-
nance (including capital repairs and replacement) and operation of the quarters and facilities as the Tribal Health Program shall determine.

“(2) RETROCESSION OF AUTHORITY.—If a Tribal Health Program which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying federally owned quarters, such retrocession shall become effective on the earlier of—

“(A) the first day of the month that begins no less than 180 days after the Tribal Health Program notifies the Secretary of its desire to retrocede; or

“(B) such other date as may be mutually agreed by the Secretary and the Tribal Health Program.

“(c) RATES IN ALASKA.—To the extent that a Tribal Health Program, pursuant to authority granted in subsection (a), establishes rental rates for federally owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.
“SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.

(a) APPLICABILITY.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a ‘Made in America’ inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(c) DEFINITIONS.—For purposes of this section, the term ‘Buy American Act’ means title III of the Act entitled ‘An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes’, approved March 3, 1933 (41 U.S.C. 10a et seq.).
“SEC. 316. OTHER FUNDING FOR FACILITIES.

“(a) Authority To Accept Funds.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into Funding Agreements. Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

“(b) Interagency Agreements.—The Secretary is authorized to enter into interagency agreements with other Federal agencies or State agencies and other entities and to accept funds from such Federal or State agencies or other sources to provide for the planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds were appropriated or for which the funds were otherwise provided.

“(c) Transferred Funds.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.
“(d) Establishment of Standards.—The Secretary, through the Service, shall establish standards by regulation, developed by rulemaking under section 802, for the planning, design, and construction of health care facilities serving Indians under this Act.


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

“TITLE IV—ACCESS TO HEALTH SERVICES


“(a) Disregard of Medicare, Medicaid, and SCHIP Payments in Determining Appropriations.—Any payments received by an Indian Health Program or by an Urban Indian Organization made under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

“(b) Nonpreferential Treatment.—Nothing in this Act authorizes the Secretary to provide services to an Indian with coverage under title XVIII, XIX, or XXI of...
the Social Security Act in preference to an Indian without
such coverage.

“(c) Use of Funds.—

“(1) Special Fund.—Notwithstanding any
other provision of law, but subject to paragraph (2), pay-
ments to which a facility of the Service is entitled by rea-
sion of a provision of the Social Security Act shall be
placed in a special fund to be held by the Secretary and
first used (to such extent or in such amounts as are pro-
vided in appropriation Acts) for the purpose of making
any improvements in the programs of the Service which
may be necessary to achieve or maintain compliance with
the applicable conditions and requirements of titles
XVIII, XIX, and XXI of the Social Security Act. Any
amounts to be reimbursed that are in excess of the
amount necessary to achieve or maintain such conditions
and requirements shall, subject to the consultation with
Indian Tribes being served by the Service Unit, be used
for reducing the health resource deficiencies of the Indian
Tribes. In making payments from such fund, the Sec-
retary shall ensure that each Service Unit of the Service
receives 100 percent of the amount to which the facilities
of the Service, for which such Service Unit makes collec-
tions, are entitled by reason of a provision of the Social
Security Act.
“(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply upon the election of a Tribal Health Program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided during the period of such election.

“(d) DIRECT BILLING.—

“(1) IN GENERAL.—A Tribal Health Program may directly bill for, and receive payment for, health care items and services provided by such Indian tribe or organization for which payment is made under title XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.

“(2) DIRECT REIMBURSEMENT.—

“(A) USE OF FUNDS.—Each Tribal Health Program exercising the option described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to any other provision of law, but all amounts so reimbursed shall be used by the Tribal Health Program for the purpose of making any improvements in Tribal facilities or Tribal Health Programs that
may be necessary to achieve or maintain com-
pliance with the conditions and requirements
applicable generally to such items and services
under the program under such title and to pro-
vide additional health care services, improve-
ments in health care facilities and Tribal
Health Programs, any health care-related pur-
pose, or otherwise to achieve the objectives pro-
vided in section 3 of this Act.

“(B) Audits.—The amounts paid to an
Indian Tribe or Tribal Organization exercising
the option described in paragraph (1) with re-
spect to a program under a title of the Social
Security Act shall be subject to all auditing re-
quirements applicable to programs administered
by an Indian Health Program.

“(3) Examination and Implementation of
Changes.—The Secretary, acting through the Serv-
ice and with the assistance of the Administrator of
the Centers for Medicare & Medicaid Services, shall
examine on an ongoing basis and implement any ad-
ministrative changes that may be necessary to facili-
tate direct billing and reimbursement under the pro-
gram established under this subsection, including
any agreements with States that may be necessary
to provide for direct billing under a program under a title of the Social Security Act.

“(4) WITHDRAWAL FROM PROGRAM.—A Tribal Health Program that bills directly under the program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary’s acceptance of the withdrawal of participation in this program.

“SEC. 402. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

“(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary, acting through the Service, shall make grants to or enter into Funding Agreements with Indian Tribes and Tribal Organizations to assist such Tribes and Tribal Organizations in establishing and ad-
ministering programs on or near reservations and trust lands to assist individual Indians—

“(1) to enroll for benefits under title XVIII, XIX, or XXI of the Social Security Act and other health benefits programs; and

“(2) to pay premiums for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Tribe or Tribes).

“(b) CONDITIONS.—The Secretary, acting through the Service, shall place conditions as deemed necessary to effect the purpose of this section in any grant or Funding Agreement which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section. Such conditions shall include requirements that the Indian Tribe or Tribal Organization successfully undertake—

“(1) to determine the population of Indians eligible for the benefits described in subsection (a);

“(2) to educate Indians with respect to the benefits available under the respective programs;

“(3) to provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits; and
“(4) to develop and implement methods of improving the participation of Indians in receiving the benefits provided under titles XVIII, XIX, and XXI of the Social Security Act.

“(c) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT PROGRAMS.—

“(1) AGREEMENTS WITH SECRETARY TO IMPROVE RECEIPT AND PROCESSING OF APPLICATIONS.—

“(A) Authorization.—The Secretary, acting through the Service, may enter into an agreement with an Indian Tribe, Tribal Organization, or Urban Indian Organization which provides for the receipt and processing of applications by Indians for assistance under titles XIX and XXI of the Social Security Act, and benefits under title XVIII of such Act, by an Indian Health Program or Urban Indian Organization.

“(B) REIMBURSEMENT OF COSTS.—Such agreements may provide for reimbursement of costs of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may, as ap
propriate, be added to the applicable rate per encounter or be provided as a separate fee-for-service payment to the Indian Tribe or Tribal Organization.

“(C) Processing clarified.—In this paragraph, the term ‘processing’ does not include a final determination of eligibility.

“(2) Agreements with states for outreach on or near reservation.—

“(A) In general.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under title XIX or XXI of the Social Security Act, as a condition of continuing approval of a State plan under such title, the State shall take steps as to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with Indian Tribes and Tribal Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are provided.

“(B) Construction.—Nothing in subparagraph (A) shall be construed as affecting
arrangements entered into between States and Indian Tribes and Tribal Organizations for such Indian Tribes and Tribal Organizations to conduct administrative activities under such titles.

“(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations.

“(e) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

“(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to Urban Indian Organizations with respect to populations served by such organizations in the same manner they apply to grants and Funding Agreements with Indian tribes and Tribal Organizations with respect to programs on or near reservations.

“(2) REQUIREMENTS.—The Secretary shall include in the grants or Funding Agreements made or provided under paragraph (1) requirements that are—
(A) consistent with the requirements im-
posed by the Secretary under subsection (b);
(B) appropriate to Urban Indian Organi-
zations and Urban Indians; and
(C) necessary to effect the purposes of
this section.

“SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PAR-
ties of Costs of Health Services.

“(a) Right of Recovery.—Except as provided in
subsection (f), the United States, an Indian Tribe, or
Tribal Organization shall have the right to recover from
an insurance company, health maintenance organization,
employee benefit plan, third-party tortfeasor, or any other
responsible or liable third party (including a political sub-
division or local governmental entity of a State) the rea-
sonable charges billed (or, if charges are not billed, the
operational, administrative, and other expenses incurred)
by the Secretary, an Indian Tribe, or Tribal Organization
in providing health services, through the Service, an In-
dian Tribe, or Tribal Organization to any individual to the
same extent that such individual, or any nongovernmental
provider of such services, would be eligible to receive dam-
ages, reimbursement, or indemnification for such charges
or expenses if—
“(1) such services had been provided by a non-
governmental provider; and
“(2) such individual had been required to pay
such charges or expenses and did pay such charges
or expenses.
“(b) LIMITATIONS ON RECOVERIES FROM STATES.—
Subsection (a) shall provide a right of recovery against
any State, only if the injury, illness, or disability for which
health services were provided is covered under—
“(1) workers’ compensation laws; or
“(2) a no-fault automobile accident insurance
plan or program.
“(c) NONAPPLICATION OF OTHER LAWS.—No law of
any State, or of any political subdivision of a State and
no provision of any contract, insurance or health mainte-
nance organization policy, employee benefit plan, self-in-
surance plan, managed care plan, or other health care plan
or program entered into or renewed after the date of the
enactment of the Indian Health Care Amendments of
1988, shall prevent or hinder the right of recovery of the
United States, an Indian Tribe, or Tribal Organization
under subsection (a).
“(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—
No action taken by the United States, an Indian Tribe,
or Tribal Organization to enforce the right of recovery
provided under subsection (a) shall operate to deny to the
injured person the recovery for that portion of the person’s
damage not covered hereunder.

“(e) ENFORCEMENT.—

“(1) IN GENERAL.—The United States, an In-
dian Tribe, or Tribal Organization may enforce the
right of recovery provided under subsection (a) by—

“(A) intervening or joining in any civil ac-
tion or proceeding brought—

“(i) by the individual for whom health
services were provided by the Secretary, an
Indian Tribe, or Tribal Organization; or

“(ii) by any representative or heirs of
such individual, or

“(B) instituting a civil action, including a
civil action for injunctive relief and other relief
and including, with respect to a political sub-
division or local governmental entity of a State,
such an action against an official thereof.

“(2) NOTICE.—All reasonable efforts shall be
made to provide notice of action instituted under
paragraph (1)(B) to the individual to whom health
services were provided, either before or during the
pendency of such action.
“(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or Urban Indian Organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

“(g) COSTS AND ATTORNEYS’ FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorneys’ fees and costs of litigation.

“(h) RIGHT OF ACTION AGAINST INSURERS, HMOs, EMPLOYEE BENEFIT PLANS, SELF-INSURANCE PLANS, AND OTHER HEALTH CARE PLANS OR PROGRAMS.—Where an insurance company, health maintenance organization, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program fails or refuses to pay the amount due under subsection (a) for services provided to an individual who is a beneficiary,
participant, or insured of such company, organization, plan, or program, the United States, Indian Tribe, or Tribal Organization shall have a right to assert and pursue all the claims and remedies against such company, organization, plan, or program and against the fiduciaries of such company, organization, plan, or program that the individual could assert or pursue under the terms of the contract, program, or plan or applicable Federal, State, or Tribal law.

“(i) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian Tribe or Tribal Organization based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

“(j) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—The previous provisions of this section shall apply to Urban Indian Organizations with respect to populations served by such Organizations in the same manner they apply to Indian Tribes and Tribal Organizations with re-
spect to populations served by such Indian Tribes and Tribal Organizations.

“(k) STATUTE OF LIMITATIONS.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

“(l) SAVINGS.—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian Tribe, or Tribal Organization under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.).

“SEC. 404. CREDITING OF REIMBURSEMENTS.

“(a) USE OF AMOUNTS.—

“(1) RETENTION BY PROGRAM.—Except as provided in section 202(g) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, or by an Urban Indian Organi-
zation, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

“(2) Programs covered.—The programs referred to in paragraph (1) are the following:

“(A) Titles XVIII, XIX, and XXI of the Social Security Act.

“(B) This Act, including section 807.

“(C) Public Law 87–693.

“(D) Any other provision of law.

“(b) No offset of amounts.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

“SEC. 405. PURCHASING HEALTH CARE COVERAGE.

“(a) In general.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act, or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for health benefits for Service
beneficiaries, Indian Tribes, Tribal Organizations, and Urban Indian Organizations may use such amounts to purchase health benefits coverage for such beneficiaries in any manner, including through—

“(1) a tribally owned and operated health care plan;

“(2) a State or locally authorized or licensed health care plan;

“(3) a health insurance provider or managed care organization; or

“(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

“(b) EXPENSES FOR SELF-INSURED PLAN.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

“(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).
“SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

“(a) AUTHORITY.—

“(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

“(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

“(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

“(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

“(2) the quality of health care services provided to any Indian through the Service;
“(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

“(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

“(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

“(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

“(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.

“SEC. 407. PAYOR OF LAST RESORT.

“Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the payor of last resort for services provided to persons eligible for services from Indian Health Programs and Urban In-
“SEC. 408. NONDISCRIMINATION IN QUALIFICATIONS FOR
REIMBURSEMENT FOR SERVICES.

“For purposes of determining the eligibility of an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization to receive payment or reimbursement from any federally funded health care program for health care services it furnishes to an Indian, any requirement that the entity be licensed or recognized under State or local law to furnish such services shall be deemed to have been met if the entity meets quality requirements for the furnishing of such services recognized by the Secretary.

“SEC. 409. CONSULTATION.

“(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP (TAG).—

“(1) ESTABLISHMENT AND MEMBERSHIP.—The Secretary shall establish a National Indian Technical Advisory Group (in this subsection referred to as the ‘Advisory Group’) which shall have no fewer than 14 members including at least 1 member designated by the Indian Tribes and Tribal Organizations in each Service Area, 1 Urban Indian Organization representative, and 1 member representing the Service.
The Secretary may appoint additional members upon the recommendation of the Advisory Group.

“(2) Duties.—

“(A) Identification of Issues.—The Advisory Group shall assist the Secretary in identifying and addressing issues regarding the health care programs under the Social Security Act (including medicare, medicaid, and SCHIP) that have implications for Indian Health Programs or Urban Indian Organizations. The Advisory Group shall provide advice to the Secretary with respect to those issues and with respect to the need for the Secretary to engage in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

“(B) Construction.—Nothing in sub-paragraph (A) shall be construed as affecting any requirement under any applicable Executive order for the Secretary to consult with Indian Tribes in cases of health care policies that have implications for Indian Health Programs or Urban Indian Organizations.

“(3) Funding.—The Secretary shall pay the expenses of the Advisory Group using the general
administrative funds of the Centers for Medicare & Medicaid Services.


“(5) MEETINGS.—The Secretary shall convene meetings of the Advisory Group no less frequently than quarterly.

“(b) SOLICITATION OF MEDICAID ADVICE.—

“(1) IN GENERAL.—As a requirement for payment under title XIX of the Social Security Act to a State in which the Service operates or funds health care programs or in which 1 or more Indian Health Programs or Urban Indian Organizations provide health care in the State for which medical assistance is available under such title, the State shall establish a process under which the State seeks advice on a regular, ongoing basis (at least on a quarterly basis) from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of such title to such Indian Health Programs and Urban Indian Organizations.
“(2) MANNER OF ADVICE.—Such process shall be in addition to (and not in lieu of) any consultation otherwise required by law and shall apply before the submittal of plan amendments, waiver requests, and proposals for demonstration projects. Such process may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its medicaid plan.

“(3) PAYMENT OF EXPENSES.—Expenses in carrying out this subsection shall be treated as reasonable administrative expenses for which reimbursement may be made under section 1903(a) of the Social Security Act.

“(c) CONSTRUCTION.—Nothing in this section shall be construed as superseding existing advisory committees, working groups, or other advisory procedures established by the Secretary or by any State.

“SEC. 410. STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP).

“(a) AUTHORIZATION FOR ARRANGEMENTS.—Notwithstanding any other provision of law, insofar as the State health plan of a State under title XXI of the Social Security Act may provide (whether through its medicaid
plan under title XIX of such Act or otherwise) child or
other health assistance to individuals who are otherwise
served by the Service or by an Indian Tribe or Tribal Or-
ganization, the Secretary may enter into an arrangement
with the State and with the Service or 1 or more Indian
Tribes and Tribal Organizations in the State under which
a portion of the funds otherwise made available to the
State under such title with respect to such individuals is
provided to the Service, Indian Tribe, or Tribal Organiza-
tion, respectively, for the purpose of providing such assist-
ance to such individuals consistent with the purposes of
such title.

“(b) ENTERING INTO ARRANGEMENTS.—

“(1) IN GENERAL.—Notwithstanding any other
provision of law, in the case of a State which has an
unexpended allotment amount described in para-
graph (2) for a fiscal year, before effecting any real-
lotment of such amount to other States, at the re-
quest of the Service or 1 or more Indian Tribes or
Tribal Organizations that operate in the State with
respect to individuals who are served by such Serv-
ice, Indian Tribes, or Tribal Organizations, the Sec-
retary shall enter into an arrangement with the
Service, Indian Tribes, or Tribal Organizations
under which the Indian child proportion (as defined
in paragraph (3)) for such Service, Indian Tribes, or Tribal Organizations of such unexpended allotment amount is made available to the Service or such Indian Tribes or Tribal Organizations for the purpose of providing child health or other assistance to individuals who are otherwise served by the Service or by such Indian Tribes or Tribal Organizations consistent with the purposes of title XXI of the Social Security Act. Insofar as amounts are made available under the preceding sentence, such amounts shall be treated (for purposes of title XXI of the Social Security Act) as if they had been expended during the period referred to in paragraph (2).

“(2) UNEXPENDED ALLOTMENT AMOUNT.—For purposes of this subsection, the term ‘unexpended allotment amount’ means, with respect to an allotment to a State under section 2104 of the Social Security Act for a fiscal year, the portion of such allotment which was not expended by the State during the period in which such allotment is available for expenditure by the State and which would, but for this subsection, be reallocated to other States.

“(3) INDIAN CHILD PROPORTION.—For purposes of this subsection, the term ‘Indian child pro-
portion’ means, with respect to an unexpended allotment amount for a State and an arrangement under paragraph (1) with the Service or Indian Tribes or Tribal Organizations, the proportion of targeted low-income children in the State (as defined in section 2110(b) of the Social Security Act) who are Indians who would be served under an arrangement with the Service or such Indian Tribes or Tribal Organizations under such paragraph, as estimated by the Secretary of Health and Human Services based upon the best available data before a portion of the unexpended allotment amount is made available under this subsection.

“SEC. 411. SOCIAL SECURITY ACT SANCTIONS.

“(a) Requests for Waiver of Sanctions.—For purposes of applying any authority under a provision of title XI, XVIII, XIX, or XXI of the Social Security Act to seek a waiver of a sanction imposed against a health care provider insofar as that provider provides services to individuals through an Indian Health Program, any requirement that a State request such a waiver shall be deemed to be met if such Indian Health Program requests such a waiver.

“(b) Safe Harbor for Transactions Between and Among Indian Health Care Programs.—For
purposes of applying section 1128B(b) of the Social Security Act, the exchange of anything of value between or among the following shall not be treated as remuneration if the exchange arises from or relates to any of the following health programs:

“(1) An exchange between or among the following:

“(A) Any Indian Health Program.

“(B) Any Urban Indian Organization.

“(2) An exchange between an Indian Tribe, Tribal Organization, or an Urban Indian Organization and any patient served or eligible for service from an Indian Tribe, Tribal Organization, or Urban Indian Organization, including patients served or eligible for service pursuant to section 807, but only if such exchange—

“(A) is for the purpose of transporting the patient for the provision of health care items or services;

“(B) is for the purpose of providing housing to the patient (including a pregnant patient) and immediate family members or an escort incidental to assuring the timely provision of health care items and services to the patient;
“(C) is for the purpose of paying premiums, copayments, deductibles, or other cost-sharing on behalf of patients; or

“(D) consists of an item or service of small value that is provided as a reasonable incentive to secure timely and necessary preventive and other items and services.

“(3) Such other exchanges involving an Indian Health Program, an Urban Indian Organization, or an Indian Tribe or Tribal Organization as meet such standards as the Secretary of Health and Human Services, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations and of patients served by Indian Health Programs, Urban Indian Organizations, Indian Tribes, and Tribal Organizations.

“SEC. 412. COST SHARING.

“(a) COINSURANCE, COPAYMENTS, AND DEDUCTIBLES.—Notwithstanding any other provision of Federal or State law—

“(1) PROTECTION FOR ELIGIBLE INDIANS UNDER SOCIAL SECURITY ACT HEALTH PROGRAMS.—No Indian who is furnished an item or
service for which payment may be made under title XVIII, XIX, or XXI of the Social Security Act may be charged a deductible, copayment, or coinsurance if the item or service is furnished by, or upon referral made by, the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

“(2) PROTECTION FOR INDIANS.—No Indian who is furnished an item or service by the Service may be charged a deductible, copayment, or coinsurance.

“(3) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—The payment or reimbursement due to the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization under title XVIII, XIX, or XXI of the Social Security Act may not be reduced by the amount of the deductible, copayment, or coinsurance that would be due from the Indian but for the operation of this section.

“(b) EXEMPTION FROM MEDICAID AND SCHIP PREMIUMS.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for services under title XIX of the Social Security Act (relating to the medicaid program) or title XXI of such Act (relating to the State children’s health insurance program) may
be charged a premium as a condition of receiving benefits under the program under the respective title.

“(c) MEDICALLY NEEDY PROGRAM SPEND-DOWN.—
For the purposes of determining the eligibility of an Indian for medical assistance under any medically needy option under a State’s medicaid plan under title XIX of the Social Security Act, the cost of providing services to an Indian in a health program of the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization shall be deemed to have been an expenditure for health care by the Indian.

“(d) LIMITATION ON MEDICAL CHILD SUPPORT RECOVERY.—Notwithstanding any other provision of law, a parent (whether or not an Indian) of an Indian child shall not be responsible for reimbursing a State or the Federal Government under title XIX or XXI of the Social Security Act for the cost of medical services relating to the child (including childbirth and including, where such child is a minor parent, any child of such minor parent) under circumstances in which payment would have been made under the contract health services program of an Indian Health Program but for the child’s (or, in the case of medical services relating to childbirth, mother’s, or grandchild’s, as the case may be) eligibility under title XIX or XXI of the Social Security Act.
“(e) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID ELIGIBILITY.—Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services under title XIX of the Social Security Act:

“(1) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State, or Tribal law or custom from recourse and including public domain allotments.

“(2) Property that has unique religious or cultural significance or that supports subsistence or traditional lifestyle according to applicable Tribal law or custom.

“(f) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Income, resources, and property that are exempt from medicaid estate recovery under title XIX of the Social Security Act as of April 1, 2003, under manual instructions issued to carry out section 1917(b)(3) of such Act because of Federal responsibility for Indian Tribes and Alaska Native Villages shall remain so exempt. Nothing in this subsection shall be construed as preventing the Secretary from providing additional medicaid estate recovery exemptions for Indians.
“SEC. 413. TREATMENT UNDER MEDICAID MANAGED CARE.

“(a) PAYMENT FOR SERVICES FURNISHED TO INDIANS.—In the case of an Indian who is enrolled with a managed care entity under section 1932 of the Social Security Act (or otherwise under a waiver under title XIX of such Act) and who receives covered services from an Indian Health Program or an Urban Indian Organization, either—

“(1) the entity shall make payment to the Indian Health Program or Urban Indian Organization at a rate established by the entity for such services that is not less than the rate for preferred providers (or at such other rate as may be negotiated between the entity and such Indian Health Program or Urban Indian Organization) and shall not require submittal of a claim by the enrollee as a condition of payment to the Indian Health Program or Urban Indian Organization; or

“(2) the State shall provide for payment to the Indian Health Program or Urban Indian Organization under its State plan under title XIX of such Act at the rate otherwise applicable and shall provide for an appropriate adjustment of the capitation payment made to the entity to take into account such payment.

“(b) OFFERING OF MANAGED CARE.—If—
“(1) a State elects under its State plan under title XIX of the Social Security Act to provide services through medicaid managed care organizations or through primary care case managers under section 1932 or under a waiver under such title; and

“(2) the Indian Health Program or Urban Indian Organization that is funded in whole or in part by the Service, or a consortium thereof, has established a medicaid managed care organization or a primary care case manager that meets quality standards equivalent to those required of such an organization or manager under such section or waiver,

the State shall enter into an agreement under such section with the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization, or such consortium, to serve as a medicaid managed care organization or a primary care case manager, respectively with respect to Indians served by such entity. In carrying out this subsection, the Secretary and the State may waive requirements regarding enrollment, capitalization, and such other matters that might otherwise prevent the application of the previous sentence.

“SEC. 414. NAVAJO NATION MEDICAID AGENCY.

“(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to treat the Nav-
ajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation.

“(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and pay all expenditures for the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act and related administrative funds under such title, which are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

“(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other single State medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

“(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such
Nation, include Western and traditional Navajo healing
services) within the Navajo Nation.

“(e) FMAP.—Notwithstanding section 1905(b) of
the Social Security Act, the Federal medical assistance
percentage shall be 100 per centum with respect to
amounts the Navajo Nation Medicaid Agency expends for
medical assistance for services and for related administra-
tive costs.

“(f) DEMONSTRATION FUNDING.—The Secretary is
further authorized to assist the Navajo Nation by pro-
viding funding including demonstration grant funding for
this project.

“(g) WAIVER AUTHORITY.—The Secretary shall have
the authority to waive applicable provisions of title XIX
of the Social Security Act to establish, develop, and imple-
ment the Navajo Nation Medicaid Agency.

“(h) OPTIONAL APPLICATION TO SCHIP.—In the
option of the Navajo Nation, the Secretary is authorized
to treat the Navajo Nation as a State for the purposes
of title XXI of the Social Security Act (relating to the
State children’s health insurance program) under terms
equivalent to those described in subsections (a) through
(g).
“SEC. 415. AUTHORIZATION OF APPROPRIATIONS.

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

“TITLE V—HEALTH SERVICES FOR URBAN INDIANS

“SEC. 501. PURPOSE.

“The purpose of this title is to establish programs in Urban Centers to make health services more accessible and available to Urban Indians.

“SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

“Under authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, or make grants to, Urban Indian Organizations to assist such organizations in the establishment and administration, within Urban Centers, of programs which meet the requirements set forth in this title. Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Secretary makes to, any Urban Indian Organization pursuant to this title.
SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

(a) REQUIREMENTS FOR GRANTS AND CONTRACTS.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, Urban Indian Organizations for the provision of health care and referral services for Urban Indians. Any such contract or grant shall include requirements that the Urban Indian Organization successfully undertake to—

“(1) estimate the population of Urban Indians residing in the Urban Center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

“(2) estimate the current health status of Urban Indians residing in such Urban Center or centers;

“(3) estimate the current health care needs of Urban Indians residing in such Urban Center or centers;

“(4) provide basic health education, including health promotion and disease prevention education, to Urban Indians;

“(5) make recommendations to the Secretary and Federal, State, local, and other resource agen-
cies on methods of improving health service pro-
grams to meet the needs of Urban Indians; and

“(6) where necessary, provide, or enter into
contracts for the provision of, health care services
for Urban Indians.

“(b) CRITERIA.—The Secretary, acting through the
Service, shall by regulation adopted pursuant to section
520 prescribe the criteria for selecting Urban Indian Or-
ganizations to enter into contracts or receive grants under
this section. Such criteria shall, among other factors, in-
clude—

“(1) the extent of unmet health care needs of
Urban Indians in the Urban Center or centers in-
volved;

“(2) the size of the Urban Indian population in
the Urban Center or centers involved;

“(3) the extent, if any, to which the activities
set forth in subsection (a) would duplicate any
project funded under this title;

“(4) the capability of an Urban Indian Organi-
zation to perform the activities set forth in sub-
section (a) and to enter into a contract with the Sec-
etary or to meet the requirements for receiving a
grant under this section;
“(5) the satisfactory performance and successful completion by an Urban Indian Organization of other contracts with the Secretary under this title;
“(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an Urban Center or centers; and
“(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.
“(c) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to or provide health promotion and disease prevention services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a).
“(d) IMMUNIZATION SERVICES.—
“(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under this section.
“(2) DEFINITION.—For purposes of this subsection, the term ‘immunization services’ means services to provide without charge immunizations against vaccine-preventable diseases.

“(e) MENTAL HEALTH SERVICES.—

“(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for Urban Indians through grants made to Urban Indian Organizations administering contracts entered into or receiving grants under subsection (a).

“(2) ASSESSMENT REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an Urban Indian Organization until that organization has prepared, and the Service has approved, an assessment of the following:

“(A) The mental health needs of the Urban Indian population concerned.

“(B) The mental health services and other related resources available to that population.

“(C) The barriers to obtaining those services and resources.

“(D) The needs that are unmet by such services and resources.
“(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

“(A) To prepare assessments required under paragraph (2).

“(B) To provide outreach, educational, and referral services to Urban Indians regarding the availability of direct behavioral health services, to educate Urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to Urban Indians.

“(C) To provide outpatient behavioral health services to Urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.

“(D) To develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

“(f) PREVENTION OF CHILD ABUSE.—

“(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to or provide services for Urban Indians through grants to Urban Indian Organizations administering contracts entered into or receiving
grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among Urban Indians.

“(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an Urban Indian Organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the Urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

“(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

“(A) To prepare assessments required under paragraph (2).

“(B) For the development of prevention, training, and education programs for Urban Indians, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection.
“(C) To provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to Urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to Urban Indian perpetrators of child abuse (including sexual abuse).

“(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

“(A) the support for the Urban Indian Organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

“(B) the capability and expertise demonstrated by the Urban Indian Organization to address the complex problem of child sexual abuse in the community; and

“(C) the assessment required under paragraph (2).
“(g) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an Urban Indian Organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

“SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

“(a) GRANTS AND CONTRACTS AUTHORIZED.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13; popularly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with or make grants to Urban Indian Organizations situated in Urban Centers for which contracts have not been entered into or grants have not been made under section 503.

“(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the Urban Indian Organization which the Secretary has
entered into a contract with, or made a grant to, under this section.

“(c) GRANT AND CONTRACT REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

“(1) the Urban Indian Organization successfully undertakes to—

“(A) document the health care status and unmet health care needs of Urban Indians in the Urban Center involved; and

“(B) with respect to Urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

“(2) the Urban Indian Organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

“(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.
SEC. 505. EVALUATIONS; RENEWALS.

“(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements and compliance with and performance of contracts entered into by Urban Indian Organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

“(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each Urban Indian Organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, in determining the capacity of an Urban Indian Organization to deliver quality patient care the Secretary shall, at the option of the organization—

“(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

“(2) accept in lieu of such onsite evaluation evidence of the organization’s provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

“(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under
this section, the Secretary determines that an Urban In-
dian Organization has not complied with the requirements
of a grant or complied with or satisfactorily performed a
contract under section 503, the Secretary shall, prior to
renewing such contract or grant, attempt to resolve with
the organization the areas of noncompliance or unsatisfac-
tory performance and modify the contract or grant to pre-
vent future occurrences of noncompliance or unsatisfac-
tory performance. If the Secretary determines that the
noncompliance or unsatisfactory performance cannot be
resolved and prevented in the future, the Secretary shall
not renew the contract or grant with the organization and
is authorized to enter into a contract or make a grant
under section 503 with another Urban Indian Organiza-
tion which is situated in the same Urban Center as the
Urban Indian Organization whose contract or grant is not
renewed under this section.

“(d) CONSIDERATIONS FOR RENEWALS.—In deter-
mining whether to renew a contract or grant with an
Urban Indian Organization under section 503 which has
completed performance of a contract or grant under sec-
tion 504, the Secretary shall review the records of the
Urban Indian Organization, the reports submitted under
section 507, and shall consider the results of the onsite
evaluations or accreditations under subsection (b).
“SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

“(a) PROCUREMENT.—Contracts with Urban Indian Organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of sections 1304, 3131, and 3133 of title 40, United States Code.

“(b) PAYMENTS UNDER CONTRACTS OR GRANTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

“(1) be made in their entirety by the Secretary to the Urban Indian Organization by no later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

“(2) if any portion thereof is unexpended by the Urban Indian Organization during the funding period with respect to which the payments initially apply, shall be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent
funding periods without additional justification or
documentation by the organization as a condition of
carrying forward the availability for expenditure of
such funds.

“(c) Revision or Amendment of Contracts.—
Notwithstanding any provision of law to the contrary, the
Secretary may, at the request or consent of an Urban In-
dian Organization, revise or amend any contract entered
into by the Secretary with such organization under this
title as necessary to carry out the purposes of this title.

“(d) Fair and Uniform Services and Assistance.—Contracts with or grants to Urban Indian Organi-
zations and regulations adopted pursuant to this title shall
include provisions to assure the fair and uniform provision
to Urban Indians of services and assistance under such
contracts or grants by such organizations.

“SEC. 507. REPORTS AND RECORDS.

“(a) Reports.—For each fiscal year during which
an Urban Indian Organization receives or expends funds
pursuant to a contract entered into or a grant received
pursuant to this title, such Urban Indian Organization
shall submit to the Secretary not more frequently than
every 6 months, a report that includes the following:
“(1) In the case of a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

“(2) Information on activities conducted by the organization pursuant to the contract or grant.

“(3) An accounting of the amounts and purpose for which Federal funds were expended.

“(4) A minimum set of data, using uniformly defined elements, that is specified by the Secretary in consultation, consistent with section 514, with Urban Indian Organizations.

“(b) AUDIT.—The reports and records of the Urban Indian Organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

“(c) COSTS OF AUDITS.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

“(1) a certified public accountant; or

“(2) a certified public accounting firm qualified to conduct Federal compliance audits.

“SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

“The authority of the Secretary to enter into contracts or to award grants under this title shall be to the
extent, and in an amount, provided for in appropriation Acts.

“SEC. 509. FACILITIES.

“(a) GRANTS.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

“(b) LOANS.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide to contractors or grant recipients under this title loans from the Urban Indian Health Care Facilities Revolving Loan Fund described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

“(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.
“(2) The total of the principal of loans and loan

guarantees, respectively, outstanding at any one
time shall not exceed such limitations as may be
specified in appropriation Acts.

“(3) The loan or loan guarantee may have a
term of the shorter of the estimated useful life of the
facility or 25 years.

“(4) An Urban Indian Organization may as­
sign, and the Secretary may accept assignment of,
the revenue of the Urban Indian Organization as se­
curity for a loan or loan guarantee under this sub­
section.

“(5) The Secretary shall not collect application,
processing, or similar fees from Urban Indian Orga­
nizations applying for loans or loan guarantees
under this subsection.

“(c) FUND.—

“(1) ESTABLISHMENT.—There is established in
the Treasury of the United States a fund to be
known as the Urban Indian Health Care Facilities
Revolving Loan Fund (hereafter in this section re­
ferred to as the “URLF”). The URLF shall consist
of—

“(A) such amounts as may be appropriated
to the URLF;
“(B) amounts received from Urban Indian Organizations in repayment of loans made to such organizations under paragraph (2); and

“(C) interest earned on amounts in the URLF under paragraph (3).

“(2) USE OF AMOUNT IN FUND.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to Urban Indian Organizations receiving grants or contracts under this title for the purposes, and subject to the requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from Urban Indian Organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

“(3) INVESTMENT OF AMOUNTS IN FUND.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet current withdrawals from the URLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price or by purchase of outstanding obligations at the market price. Any ob-
ligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

“(4) INITIAL FUNDS.—There are authorized to be appropriated such sums as may be necessary to initiate the URLF. For each fiscal year after the initial year in which funds are appropriated to the URLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the URLF during the preceding fiscal year and all accrued interest.

“SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

“There is hereby established within the Service an Office of Urban Indian Health, which shall be responsible for—

“(1) carrying out the provisions of this title;

“(2) providing central oversight of the programs and services authorized under this title; and

“(3) providing technical assistance to Urban Indian Organizations.

“SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

“(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based edu-
cation regarding, alcohol and substance abuse in Urban
Centers to those Urban Indian Organizations with which
the Secretary has entered into a contract under this title
or under section 201.

“(b) GOALS.—Each grant made pursuant to sub-
section (a) shall set forth the goals to be accomplished
pursuant to the grant. The goals shall be specific to each
grant as agreed to between the Secretary and the grantee.

“(c) CRITERIA.—The Secretary shall establish cri-
teria for the grants made under subsection (a), including
criteria relating to the following:

“(1) The size of the Urban Indian population.

“(2) Capability of the organization to ade-
quately perform the activities required under the
grant.

“(3) Satisfactory performance standards for the
organization in meeting the goals set forth in such
grant. The standards shall be negotiated and agreed
to between the Secretary and the grantee on a
grant-by-grant basis.

“(4) Identification of the need for services.

“(d) ALLOCATION OF GRANTS.—The Secretary shall
develop a methodology for allocating grants made pursu-
ant to this section based on the criteria established pursu-
ant to subsection (c).
“(e) Grants Subject to Criteria.—Any funds received by an Urban Indian Organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

“SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

“Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

“(1) be permanent programs within the Service’s direct care program;

“(2) continue to be treated as Service Units in the allocation of resources and coordination of care; and

“(3) shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act, except that the programs shall not be divisible.

“SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

“(a) Grants and Contracts.—The Secretary, through the Office of Urban Indian Health, shall make grants or enter into contracts with Urban Indian Organizations for the administration of Urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (here-
after in this section referred to as ‘NIAAA’) and trans­ferred to the Service. Such grants and contracts shall be­come effective no later than September 30, 2004.

“(b) Use of Funds.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for Urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

“(c) Eligibility.—Urban Indian Organizations that operate Indian alcohol programs originally funded under the NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

“(d) Report.—The Secretary shall evaluate and re­port to Congress on the activities of programs funded under this section not less than every 5 years.

“Sec. 514. Consultation with Urban Indian Organizations.

“(a) In General.—The Secretary shall ensure that the Service, the Centers for Medicare & Medicaid Services, and other operating divisions and staff divisions of the De­partment consult, to the greatest extent practicable, with Urban Indian Organizations prior to taking any action, or approving Federal financial assistance for any action.
of a State, that may affect Urban Indians or Urban Indian Organizations.

“(b) Definition of Consultation.—For purposes of subsection (a), consultation is the open and free exchange of information and opinion among Urban Indian Organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

“Sec. 515. Federal Tort Claim Act Coverage.

“(a) In General.—With respect to claims resulting from the performance of functions during fiscal year 2004 and thereafter, or claims asserted after September 30, 2003, but resulting from the performance of functions prior to fiscal year 2004, under a contract, grant agreement, or any other agreement authorized under this title, an Urban Indian Organization is deemed hereafter to be part of the Service in the Department of Health and Human Services while carrying out any such contract or agreement and its employees are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or agreement. After September 30, 2003, any civil action or proceeding involving such claims brought hereafter against any Urban Indian Organization or any employee of such Urban Indian Orga-
nization covered by this provision shall be deemed to be
an action against the United States and will be defended
by the Attorney General and be afforded the full protec-
tion and coverage of the Federal Tort Claims Act (28
U.S.C. 1346(b), 2671 et seq.).

“(b) CLAIMS RESULTING FROM PERFORMANCE OF
CONTRACT OR GRANT.—Beginning with the fiscal year
ending September 30, 2003, and thereafter, the appro-
priate Secretary shall request through annual appropri-
tions funds sufficient to reimburse the Treasury for any
claims paid in the prior fiscal year pursuant to the fore-
going provisions.

“(c) EFFECT ON ISDEAA.—Nothing in this section
shall in any way affect the provisions of section 102(d)
of the Indian Self-Determination and Education Assist-
ance Act of 1975 (25 U.S.C. 450f(d)).

“SEC. 516. URBAN YOUTH TREATMENT CENTER DEM-
ONSTRATION.

“(a) CONSTRUCTION AND OPERATION.—The Sec-
retary, acting through the Service, through grant or con-
tract, shall make payment for the construction and oper-
atation of at least 2 residential treatment centers in each
State described in subsection (b) to demonstrate the provi-
sion of alcohol and substance abuse treatment services to
Urban Indian youth in a culturally competent residential setting.

“(b) Definition of State.—A State described in this subsection is a State in which—

“(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and

“(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

“Sec. 517. Use of Federal Government Facilities and Sources of Supply.

“(a) Authorization for Use.—The Secretary, acting through the Service, shall allow an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary’s jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

“(b) Donations.—Subject to subsection (d), the Secretary may donate to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined
to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

“(c) Acquisition of Property for Donation.—
The Secretary may acquire excess or surplus government personal or real property for donation (subject to subsection (d)), to an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the Urban Indian Organization for a purpose for which a contract or grant is authorized under this title.

“(d) Priority.—In the event that the Secretary receives a request for donation of a specific item of personal or real property described in subsection (b) or (c) from both an Urban Indian Organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation of the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the Secretary transfers the property physically to the Urban Indian Organization.

“(e) Urban Indian Organizations Deemed Executive Agency for Certain Purposes.—For pur-

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poses of section 501 of title 40, United States Code, (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an Urban Indian Organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the Urban Indian Organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

“SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

“(a) GRANTS AUTHORIZED.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

“(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

“(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a) relating to the following:
“(1) The size and location of the Urban Indian population to be served.

“(2) The need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served.

“(3) Performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee.

“(4) The capability of the organization to adequately perform the activities required under the grant.

“(5) The willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

“(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

“SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

“...
dian Organizations for the employment of Indians trained
as health service providers through the Community Health
Representatives Program under section 109 in the provi-
sion of health care, health promotion, and disease preven-
tion services to Urban Indians.

"SEC. 520. REGULATIONS.

"(a) REQUIREMENTS FOR REGULATIONS.—The Sec-
retary may promulgate regulations to implement the provi-
sions of this title in accordance with the following:

"(1) Proposed regulations to implement this
Act shall be published in the Federal Register by the
Secretary no later than 9 months after the date of
the enactment of this Act and shall have no less
than a 4-month comment period.

"(2) The authority to promulgate regulations
under this Act shall expire 18 months from the date
of the enactment of this Act.

"(b) EFFECTIVE DATE OF TITLE.—The amendments
to this title made by the Indian Health Care Improvement
Act Amendments of 2003 shall be effective on the date
of the enactment of such amendments, regardless of
whether the Secretary has promulgated regulations imple-
menting such amendments have been promulgated.
“SEC. 521. ELIGIBILITY FOR SERVICES.

“Urban Indians shall be eligible for health care or referral services provided pursuant to this title.

“SEC. 522. AUTHORIZATION OF APPROPRIATIONS.

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

“TITLE VI—ORGANIZATIONAL IMPROVEMENTS

“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

“(a) Establishment.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services provided under Federal statute or treaties to Indians and Indian Tribes, there was established within the Public Health Service of the Department the Indian Health Service.

“(b) Director.—The Indian Health Service is an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health
Service shall report to the Secretary through the Assistant Secretary for Health of the Department of Health and Human Services. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

“(c) DUTIES.—The Secretary shall carry out through the Director of the Indian Health Service—

“(1) all functions which were, on the day before the date of the enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

“(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and use of, health services for Indians;

“(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including but not limited to programs under—

“(A) this Act;

“(B) the Act of November 2, 1921 (25 U.S.C. 13);
“(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.); 
“(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and 
“(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.); and 
“(4) all scholarship and loan functions carried out under title I.

“(d) AUTHORITIES.—(1) The Director shall have the authority—
“(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code; 
“(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and 
“(C) to manage, expend, and obligate all funds appropriated for the Service.
“(2) Notwithstanding any other law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).
“SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

(a)(1) The Secretary shall establish an automated management information system for the Service.

(2) The information system established under paragraph (1) shall include—

(A) a financial management system;

(B) a patient care information system for each area served by the Service;

(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service;

(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area Office of the Service;

(E) an interface mechanism for patient billing and accounts receivable system; and

(F) a training component.

(b) The Secretary shall provide each Tribal Health Program automated management information systems which—

(1) meet the management information needs of such Tribal Health Program with respect to the treatment by the Tribal Health Program of patients of the Service; and
“(2) meet the management information needs of the Service.

“(c) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

“(d) The Director shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

“SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

“SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

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

“TITLE VII—BEHAVIORAL HEALTH PROGRAMS

“SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

“(a) PURPOSES.—The purposes of this section are as follows:

“(1) To authorize and direct the Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, to develop a comprehensive behavioral health prevention
and treatment program which emphasizes collabora-
tion among alcohol and substance abuse, social serv-
ices, and mental health programs.

“(2) To provide information, direction, and
guidance relating to mental illness and dysfunction
and self-destructive behavior, including child abuse
and family violence, to those Federal, tribal, State,
and local agencies responsible for programs in In-
dian communities in areas of health care, education,
social services, child and family welfare, alcohol and
substance abuse, law enforcement, and judicial serv-
ices.

“(3) To assist Indian Tribes to identify services
and resources available to address mental illness and
dysfunctional and self-destructive behavior.

“(4) To provide authority and opportunities for
Indian Tribes and Tribal Organizations to develop,
implement, and coordinate with community-based
programs which include identification, prevention,
education, referral, and treatment services, including
through multidisciplinary resource teams.

“(5) To ensure that Indians, as citizens of the
United States and of the States in which they re-
side, have the same access to behavioral health serv-
ices to which all citizens have access.
“(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

“(b) PLANS.—

“(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

“(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

“(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

“(ii) an estimate of the financial and human cost attributable to such illness or behavior.
“(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

“(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to meet their responsibilities under the plans.

“(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, Urban Indian Organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, Urban Indian Organization, or the Service.

“(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.
“(c) PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, to the extent feasible and if funding is available, programs including the following:

“(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

“(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

“(B) detoxification (social and medical);

“(C) acute hospitalization;

“(D) intensive outpatient/day treatment;

“(E) residential treatment;

“(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

“(G) emergency shelter;

“(H) intensive case management; and

“(I) Traditional Health Care Practices.

“(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including the following:
“(A) Preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention.

“(B) Mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco).

“(C) Identification and treatment of co-occurring disorders and comorbidity.

“(D) Prevention of alcohol, drug, inhalant, and tobacco use.

“(E) Early intervention, treatment, and aftercare.

“(F) Promotion of healthy choices and lifestyle (related to sexually transmitted diseases, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk/safety issues).

“(G) Identification and treatment of neglect and physical, mental, and sexual abuse.

“(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including the following:

“(A) Early intervention, treatment, and aftercare.
“(B) Mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including gender specific services.

“(C) Identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity.

“(D) Promotion of gender specific healthy choices and lifestyle (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk-related behavior).

“(E) Treatment services for women at risk of giving birth to a child with a fetal alcohol disorder.

“(F) Gender specific treatment for sexual assault and domestic violence.

“(4) FAMILY CARE.—Behavioral health services for families, including the following:

“(A) Early intervention, treatment, and aftercare for affected families.

“(B) Treatment for sexual assault and domestic violence.

“(C) Promotion of healthy choices and lifestyle (related to parenting, partners, domestic violence, and other abuse issues).
“(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including the following:

“(A) Early intervention, treatment, and aftercare.

“(B) Mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including gender specific services.

“(C) Identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity.

“(D) Promotion of healthy choices and lifestyle (managing conditions related to aging).

“(E) Gender specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation.

“(F) Identification and treatment of dementias regardless of cause.

“(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

“(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, pre-
vent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

“(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization in the development and implementation of such plan.

“(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

“(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State
agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

“(f) Mental Health Care Need Assessment.— Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

“SEC. 702. MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

“(a) Contents.—Not later than 12 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memorandum of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:
“(1) The scope and nature of mental illness and
dysfunctional and self-destructive behavior, including
child abuse and family violence, among Indians.

“(2) The existing Federal, tribal, State, local,
and private services, resources, and programs avail-
able to provide mental health services for Indians.

“(3) The unmet need for additional services, re-
sources, and programs necessary to meet the needs
identified pursuant to paragraph (1).

“(4)(A) The right of Indians, as citizens of the
United States and of the States in which they re-
side, to have access to mental health services to
which all citizens have access.

“(B) The right of Indians to participate in, and
receive the benefit of, such services.

“(C) The actions necessary to protect the exer-
cise of such right.

“(5) The responsibilities of the Bureau of In-
dian Affairs and the Service, including mental health
identification, prevention, education, referral, and
treatment services (including services through multi-
disciplinary resource teams), at the central, area,
and agency and Service Unit, Service Area, and
headquarters levels to address the problems identi-
fied in paragraph (1).
“(6) A strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

“(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring mental health and substance abuse treatment; and

“(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

“(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to commu-

“(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

“(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

“(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

“(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

“(3) an estimate of the funding necessary to adequately support a program of prevention of alco-
hol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

“(c) CONSULTATION.—The Secretary, acting through the Service, and the Secretary of the Interior shall, in developing the memoranda of agreement under subsection (a), consult with and solicit the comments from—

“(1) Indian Tribes and Tribal Organizations;

“(2) Indians;

“(3) Urban Indian Organizations and other Indian organizations; and

“(4) behavioral health service providers.

“(d) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian Tribe, Tribal Organization, and Urban Indian Organization.

“SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide a program of comprehensive
behavioral health, prevention, treatment, and aftercare, including Traditional Health Care Practices, which shall include—

“(A) prevention, through educational intervention, in Indian communities;

“(B) acute detoxification, psychiatric hospitalization, and residential and intensive outpatient treatment;

“(C) community-based rehabilitation and aftercare;

“(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

“(E) specialized residential treatment programs for high-risk populations, including but not limited to pregnant and postpartum women and their children.

“(2) TARGET POPULATIONS.—The target population of such program shall be members of Indian Tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

“(b) CONTRACT HEALTH SERVICES.—
“(1) **IN GENERAL.—**The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

“(2) **PROVISION OF ASSISTANCE.—**In carrying out this subsection, the Secretary shall provide assistance to Indian Tribes and Tribal Organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

**SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.**

“(a) **IN GENERAL.—**Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a mental health technician program within the Service which—

“(1) provides for the training of Indians as mental health technicians; and

“(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.
“(b) Paraprofessional Training.—In carrying out subsection (a), the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

“(c) Supervision and Evaluation of Technicians.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall supervise and evaluate the mental health technicians in the training program.

“(d) Traditional Health Care Practices.—The Secretary, acting through the Service, shall ensure that the program established pursuant to this subsection involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served.

“SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

“Subject to the provisions of section 221, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health
care services to Indians in a clinical setting under this Act
or through a Funding Agreement shall, in the case of a
person employed as a psychologist, social worker, or mar­
riage and family therapist, be licensed as a clinical psy­
chologist, social worker, or marriage and family therapist,
respectively, or working under the direct supervision of a
licensed clinical psychologist, social worker, or marriage
and family therapist, respectively.

“SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

“(a) FUNDING.—The Secretary, consistent with sec­
tion 701, shall make funds available to Indian Tribes,
Tribal Organizations, and Urban Indian Organizations to
develop and implement a comprehensive behavioral health
program of prevention, intervention, treatment, and re­
lapse prevention services that specifically addresses the
spiritual, cultural, historical, social, and child care needs
of Indian women, regardless of age.

“(b) USE OF FUNDS.—Funds made available pursu­
ant to this section may be used to—

“(1) develop and provide community training,

education, and prevention programs for Indian

women relating to behavioral health issues, including

fetal alcohol disorders;
“(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

“(3) develop prevention and intervention models for Indian women which incorporate Traditional Health Care Practices, cultural values, and community and family involvement.

“(c) CRITERIA.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

“(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations.

“SEC. 707. INDIAN YOUTH PROGRAM.

“(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 701, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian
Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

“(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an Area Office.

“(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the Area Office in California shall be considered to be 2 Area Offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.
“(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

“(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

“(4) SPECIFIC PROVISION OF FUNDS.—

“(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

“(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

“(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section
4(1) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)).

“(B) Provision of services to eligible youths.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in such State.

“(c) Intermediate Adolescent Behavioral Health Services.—

“(1) In general.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services, which may incorporate Traditional Health Care Practices, to Indian children and adolescents, including—

“(A) pretreatment assistance;

“(B) inpatient, outpatient, and aftercare services;

“(C) emergency care;

“(D) suicide prevention and crisis intervention; and
“(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

“(2) USE OF FUNDS.—Funds provided under this subsection may be used—

“(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

“(B) to hire behavioral health professionals;

“(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

“(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

“(E) for intensive home- and community-based services.

“(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian Tribes and Tribal Organizations, establish criteria for the
review and approval of applications or proposals for
funding made available pursuant to this subsection.

“(d) FEDERALLY OWNED STRUCTURES.—

“(1) IN GENERAL.—The Secretary, in consulta-
tion with Indian Tribes and Tribal Organizations,
shall—

“(A) identify and use, where appropriate,
federally owned structures suitable for local resi-
dential or regional behavioral health treatment
for Indian youths; and

“(B) establish guidelines, in consultation
with Indian Tribes and Tribal Organizations,
for determining the suitability of any such fed­
erally owned structure to be used for local resi­
dential or regional behavioral health treatment
for Indian youths.

“(2) TERMS AND CONDITIONS FOR USE OF
STRUCTURE.—Any structure described in paragraph
(1) may be used under such terms and conditions as
may be agreed upon by the Secretary and the agency
having responsibility for the structure and any In­
dian Tribe or Tribal Organization operating the pro­
gram.

“(e) REHABILITATION AND AFTERCARE SERVICES.—
“(1) IN GENERAL.—The Secretary, Indian Tribes, or Tribal Organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service Unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

“(2) ADMINISTRATION.—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and para-professionals, including community health representatives.

“(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide for the inclusion of family mem-
bers of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

“(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including, but not limited to, alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

“SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

“Not later than 1 year after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with be-
havioral health problems. For the purposes of this sub-
section, California shall be considered to be 2 Area Offices,
1 office whose location shall be considered to encompass
the northern area of the State of California and 1 office
whose jurisdiction shall be considered to encompass the
remainder of the State of California. The Secretary shall
consider the possible conversion of existing, underused
Service hospital beds into psychiatric units to meet such
need.

“SEC. 709. TRAINING AND COMMUNITY EDUCATION.

“(a) PROGRAM.—The Secretary, in cooperation with
the Secretary of the Interior, shall develop and implement
or provide funding for Indian Tribes and Tribal Organiza-
tions to develop and implement, within each Service Unit
or tribal program, a program of community education and
involvement which shall be designed to provide concise and
timely information to the community leadership of each
tribal community. Such program shall include education
about behavioral health issues to political leaders, Tribal
judges, law enforcement personnel, members of tribal
health and education boards, health care providers includ-
ing traditional practitioners, and other critical members
of each tribal community. Community-based training (ori-
ented toward local capacity development) shall also include
tribal community provider training (designed for adult
learners from the communities receiving services for prevention, intervention, treatment, and aftercare).

“(b) INSTRUCTION.—The Secretary, acting through the Service, shall, either directly or through Indian Tribes and Tribal Organizations, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

“(c) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

“(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;
“(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

“(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

“SEC. 710. BEHAVIORAL HEALTH PROGRAM.

“(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, consistent with section 701, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

“(b) FUNDING; CRITERIA.—The Secretary may award such funding for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

“(1) The project will address significant unmet behavioral health needs among Indians.

“(2) The project will serve a significant number of Indians.

“(3) The project has the potential to deliver services in an efficient and effective manner.

“(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.
“(5) The project may deliver services in a manner consistent with Traditional Health Care Practices.

“(6) The project is coordinated with, and avoids duplication of, existing services.

“(c) EQUITABLE TREATMENT.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any Funding Agreement, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

“SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

“(a) PROGRAMS.—

“(1) Establishment.—The Secretary, consistent with section 701, acting through Indian Tribes and Tribal Organizations, shall establish and operate fetal alcohol disorder programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

“(2) Use of funds.—Funding provided pursuant to this section shall be used for the following:

“(A) To develop and provide for Indians community and in school training, education, and prevention programs relating to fetal alcohol disorders.
“(B) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian’s child.

“(C) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected Indians and their families or caretakers.

“(D) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

“(E) To develop prevention and intervention models which incorporate practitioners of Traditional Health Care Practices, cultural and spiritual values, and community involvement.

“(F) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

“(G) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.
“(H) To develop early childhood interven-
tion projects from birth on to mitigate the ef-
facts of fetal alcohol disorder among Indians.
“(I) To develop and fund community-based
adult fetal alcohol disorder housing and support
services for Indians and for women pregnant
with an Indian’s child.
“(3) CRITERIA FOR APPLICATIONS.—The Sec-
retary shall establish criteria for the review and ap-
proval of applications for funding under this section.
“(b) SERVICES.—The Secretary, acting through the
Service and Indian Tribes, Tribal Organizations, and
Urban Indian Organizations, shall—
“(1) develop and provide services for the pre-
vention, intervention, treatment, and aftercare for
those affected by fetal alcohol disorder in Indian
communities; and
“(2) provide supportive services, directly or
through an Indian Tribe, Tribal Organization, or
Urban Indian Organization, including services to
meet the special educational, vocational, school-to-
work transition, and independent living needs of ad-
olesecent and adult Indians with fetal alcohol dis-
order.
“(c) Task Force.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

“(1) The National Institute on Drug Abuse.
“(2) The National Institute on Alcohol and Alcoholism.
“(3) The Office of Substance Abuse Prevention.
“(4) The National Institute of Mental Health.
“(5) The Service.
“(7) The Administration for Native Americans.
“(8) The National Institute of Child Health and Human Development (NICHD).
“(9) The Centers for Disease Control and Prevention.
“(10) The Bureau of Indian Affairs.
“(11) Indian Tribes.
“(12) Tribal Organizations.
“(13) Urban Indian Organizations.
“(14) Indian fetal alcohol disorder experts.

“(d) Applied Research Projects.—The Secretary, acting through the Substance Abuse and Mental
Health Services Administration, shall make funding available to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and Urban Indians affected by fetal alcohol disorder.

“(e) **FUNDING FOR URBAN INDIAN ORGANIZATIONS.**—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to Urban Indian Organizations funded under title V.

**SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.**

“(a) **ESTABLISHMENT.**—The Secretary, acting through the Service, and the Secretary of the Interior, Indian Tribes, and Tribal Organizations shall establish, consistent with section 701, in every Service Area, programs involving treatment for—

“(1) victims of sexual abuse who are Indian children or children in an Indian household; and

“(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

“(b) **USE OF FUNDS.**—Funding provided pursuant to this section shall be used for the following:
“(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

“(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

“(3) To develop prevention and intervention models which incorporate Traditional Health Care Practices, cultural and spiritual values, and community involvement.

“(4) To develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

“(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—

“(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and
“(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

SEC. 713. BEHAVIORAL HEALTH RESEARCH.

“The Secretary, in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, Tribal Organizations, and Urban Indian Organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

“(1) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

“(2) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.
“SEC. 714. DEFINITIONS.

“For the purpose of this title, the following definitions shall apply:

“(1) **Assessment.**—The term ‘assessment’ means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

“(2) **Alcohol-related neurodevelopmental disorders or ARND.**—The term ‘alcohol-related neurodevelopmental disorders’ or ‘ARND’ means, with a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities. Behaviorally, there can be problems with irritability, and failure to thrive as infants. As children become older there will likely be hyperactivity, attention deficit, language dysfunction, and perceptual and judgment problems.

“(3) **Behavioral health.**—The term ‘behavioral health’ means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. This can include the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

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“(4) Behavioral health aftercare.—The term ‘behavioral health aftercare’ includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers (mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, ministers, etc.)

“(5) Dual diagnosis.—The term ‘dual diagnosis’ means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

“(6) Fetal alcohol disorders.—The term ‘fetal alcohol disorders’ means fetal alcohol syn-
drome, partial fetal alcohol syndrome and alcohol re-
lated neurodevelopmental disorder (ARND).

“(7) Fetal Alcohol Syndrome or FAS.—
The term ‘fetal alcohol syndrome’ or ‘FAS’ means a
syndrome in which, with a history of maternal alco-
hol consumption during pregnancy, the following cri-
teria are met:

“(A) Central nervous system involvement
such as developmental delay, intellectual deficit,
microencephaly, or neurologic abnormalities.

“(B) Craniofacial abnormalities with at
least 2 of the following: microophthalmia, short
palpebral fissures, poorly developed philtrum,
thin upper lip, flat nasal bridge, and short
upturned nose.

“(C) Prenatal or postnatal growth delay.

“(8) Partial FAS.—The term ‘partial FAS’
means, with a history of maternal alcohol consump-
tion during pregnancy, having most of the criteria of
FAS, though not meeting a minimum of at least 2
of the following: microophthalmia, short palpebral
fissures, poorly developed philtrum, thin upper lip,
flat nasal bridge, and short upturned nose.

“(9) Rehabilitation.—The term ‘rehabilita-
tion’ means to restore the ability or capacity to en-
gage in usual and customary life activities through education and therapy.

“(10) SUBSTANCE ABUSE.—The term ‘substance abuse’ includes inhalant abuse.

“SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2015 to carry out the provisions of this title.

“TITLE VIII—MISCELLANEOUS

“SEC. 801. REPORTS.

“The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to Congress a report containing the following:

“(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians and ensure a health status for Indians, which are at a parity with the health services available to and the health status of the general population, including specific comparisons of appropriations provided and those required for such parity.
“(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 808.

“(3) A report on the use of health services by Indians—

“(A) on a national and area or other relevant geographical basis;

“(B) by gender and age;

“(C) by source of payment and type of service;

“(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

“(E) on the services provided under Funding Agreements.

“(4) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.
“(5) A general audit report of the Secretary on the Health Care Educational Loan Repayment Program as required by section 110(n).

“(6) A report of the findings and conclusions of demonstration programs on development of educational curricula for substance abuse counseling as required in section 126(f).

“(7) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

“(8) A report of the evaluations of health promotion and disease prevention as required in section 203(e).

“(9) A biennial report to Congress on infectious diseases as required by section 212.

“(10) A report on environmental and nuclear health hazards as required by section 215.

“(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2) and 301(d).

“(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(i).

“(13) An annual report on the expenditure of nonservice funds for renovation as required by sections 304(b)(2).
“(14) A report identifying the backlog of main-
tenance and repair required at Service and tribal fa-
cilities required by section 313(a).

“(15) A report providing an accounting of reim-
bursement funds made available to the Secretary
under titles XVIII, XIX, and XXI of the Social Se-
curity Act.

“(16) A report on any arrangements for the
sharing of medical facilities or services between the
Service, Indian Tribes, and Tribal Organizations,
and the Department of Veterans Affairs and the De-
partment of Defense, as authorized by section 406.

“(17) A report on evaluation and renewal of
Urban Indian programs under section 505.

“(18) A report on the evaluation of programs
as required by section 513(d).

“(19) A report on alcohol and substance abuse
as required by section 701(f).

“SEC. 802. REGULATIONS.

“(a) DEADLINES.—

“(1) PROCEDURES.—Not later than 90 days
after the date of the enactment of the Indian Health
Care Improvement Act Amendments of 2003, the
Secretary shall initiate procedures under subchapter
III of chapter 5 of title 5, United States Code, to
negotiate and promulgate such regulations or amendments thereto that are necessary to carry out titles I, II, III, IV, and VII and section 817. The Secretary may promulgate regulations to carry out sections 105, 115, 117, and title V, using the procedures required by the Administrative Procedures Act. The Secretary shall issue no regulations to carry out titles VI and VIII, except as necessary to carry out section 817.

“(2) **PROPOSED REGULATIONS.**—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 270 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003 and shall have no less than a 120-day comment period.

“(3) **EXPIRATION OF AUTHORITY.**—The authority to promulgate regulations under this Act shall expire 18 months from the date of the enactment of this Act.

“(b) **COMMITTEE.**—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes and Tribal
Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes, Tribal Organizations, and Urban Indian Organizations from each Service Area.

“(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

“(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

“(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

“SEC. 803. PLAN OF IMPLEMENTATION.

“Not later than 8 months after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, the Secretary in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule (including a schedule of appropriation
requests), by title and section, by which the Secretary will
implement the provisions of this Act.

**SEC. 804. AVAILABILITY OF FUNDS.**

“The funds appropriated pursuant to this Act shall
remain available until expended.

**SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED
TO THE INDIAN HEALTH SERVICE.**

“Any limitation on the use of funds contained in an
Act providing appropriations for the Department for a pe­
riod with respect to the performance of abortions shall
apply for that period with respect to the performance of
abortions using funds contained in an Act providing ap­
propriations for the Service.

**SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.**

“(a) In General.—The following California Indians
shall be eligible for health services provided by the Service:

“(1) Any member of a federally recognized In­
dian Tribe.

“(2) Any descendant of an Indian who was re­
siding in California on June 1, 1852, if such de­
scendant—

“(A) is a member of the Indian community
served by a local program of the Service; and

“(B) is regarded as an Indian by the com­
community in which such descendant lives.
“(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

“(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

“(b) CLARIFICATION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

“SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

“(a) CHILDREN.—Any individual who—

“(1) has not attained 19 years of age;

“(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

“(3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs
of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

“(b) Spouses.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of the Indian Tribe(s) being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

“(c) Provision of Services to Other Individuals.—

“(1) In General.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service.
Unit and who are not otherwise eligible for such health services if—

“(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

“(B) the Secretary and the served Indian Tribes have jointly determined that—

“(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

“(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

“(2) ISDEAA PROGRAMS.—In the case of a Tribal Health Program, the governing body of the Indian Tribe or Tribal Organization providing health services under such Tribal Health Program is authorized to determine whether health services should be provided under its Funding Agreement to individuals who are not otherwise eligible for such services. In making such determination, the governing body shall take into account the considerations described in clauses (i) and (ii) of paragraph (1)(B).
“(3) PAYMENT FOR SERVICES.—

“(A) IN GENERAL.—Persons receiving health services provided by the Service under of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 404 of this Act, or any other provision of law, amounts collected under this subsection, including medicare, medicaid, or SCHIP reimbursements under titles XVIII, XIX, and XXI of the Social Security Act, shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

“(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of
paragraph (1) only if an agreement has been
entered into with a State or local government
under which the State or local government
agrees to reimburse the Service for the expenses
incurred by the Service in providing such health
services to such indigent individual.

“(4) REVOCATION OF CONSENT FOR SERV-
ICES.—

“(A) SINGLE TRIBE SERVICE AREA.—In
the case of a Service Area which serves only 1
Indian Tribe, the authority of the Secretary to
provide health services under paragraph (1)
shall terminate at the end of the fiscal year suc-
ceeding the fiscal year in which the governing
body of the Indian Tribe revokes its concur-
rence to the provision of such health services.

“(B) MULTITRIBAL SERVICE AREA.—In
the case of a multitribal Service Area, the au-
thority of the Secretary to provide health serv-
ices under paragraph (1) shall terminate at the
end of the fiscal year succeeding the fiscal year
in which at least 51 percent of the number of
Indian Tribes in the Service Area revoke their
concurrence to the provisions of such health
services.
“(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

“(1) achieve stability in a medical emergency;

“(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

“(3) provide care to non-Indian women pregnant with an eligible Indian’s child for the duration of the pregnancy through postpartum; or

“(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible individual.

“(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

Hospital privileges in health facilities operated and maintained by the Service or operated under a Funding Agreement may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible
persons as a part of the conditions under which such hos-

pital privileges are extended.

“(f) ELIGIBLE INDIAN.—For purposes of this sec-

tion, the term ‘eligible Indian’ means any Indian who is

eligible for health services provided by the Service without

regard to the provisions of this section.

“SEC. 808. REALLOCATION OF BASE RESOURCES.

“(a) REPORT REQUIRED.—Notwithstanding any

other provision of law, any allocation of Service funds for

a fiscal year that reduces by 5 percent or more from the

previous fiscal year the funding for any recurring pro-

gram, project, or activity of a Service Unit may be imple-

mented only after the Secretary has submitted to the

President, for inclusion in the report required to be trans-

mitted to Congress under section 801, a report on the pro-

posed change in allocation of funding, including the rea-

sons for the change and its likely effects.

“(b) EXCEPTION.—Subsection (a) shall not apply if

the total amount appropriated to the Service for a fiscal

year is at least 5 percent less than the amount appro-

priated to the Service for the previous fiscal year.

“SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

“The Secretary shall provide for the dissemination to

Indian Tribes, Tribal Organizations, and Urban Indian
Organizations of the findings and results of demonstration projects conducted under this Act.

“SEC. 810. PROVISION OF SERVICES IN MONTANA.

“(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

“(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

“SEC. 811. MORATORIUM.

“During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration of the Public Health Service, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until
such time as new criteria governing eligibility for services
are developed in accordance with section 802.

“SEC. 812. TRIBAL EMPLOYMENT.

“For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a Funding Agreement shall not be considered an ‘employer’.

“SEC. 813. PRIME VENDOR.

“(a) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), a Tribal Health Program shall be deemed an executive agency when carrying out a contract, grant, cooperative agreement, or Funding Agreement with the Service and shall have access to the Federal Supply Schedule and any other Federal source of supply to which executive agencies have access.

“(b) HHS STATUS.—For purposes of section 4 of Public Law 102–585 (38 U.S.C. 8126), a Tribal Health Program shall have the status of the Indian Health Service and shall have direct access to the Veterans Administration prime vendor provided for in section 4 of Public Law 102–585.
“(c) Employee Status.—The employees of such Tribal Health Programs may order supplies under such respective programs on the same basis as employees of the Service.

“SEC. 814. SEVERABILITY PROVISIONS.

“If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

“SEC. 815. ESTABLISHMENT OF NATIONAL BIPARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

“(a) Establishment.—There is hereby established the National Bipartisan Indian Health Care Entitlement Commission (the ‘Commission’).

“(b) Duties of Commission.—The duties of the Commission are the following:

“(1) To establish a study committee composed of those members of the Commission appointed by the Director and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:
“(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

“(B) To make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which will address, among other things, issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provided and the cost, including mechanisms for making funds available for the health services to be provided.

“(C) To determine the effect of the enactment of such recommendations on (i) the exist-
ing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

“(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

“(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study committee in the course of carrying out its duties under this section.

“(2) To review and analyze the recommendations of the report of the study committee.

“(3) To make recommendations to Congress for providing health services for Indians as an entitlement, giving due regard to the effects of such a program on existing health care delivery systems for In-
dians and the effect of such a program on the sover-
eign status of Indian Tribes.

“(4) Not later than 18 months following the
date of appointment of all members of the Commiss-
on, submit a written report to Congress containing
a recommendation of policies and legislation to im-
plement a policy that would establish a health care
system for Indians based on delivery of health serv-
ices as an entitlement, together with a determination
of the implications of such an entitlement system on
existing health care delivery systems for Indians and
on the sovereign status of Indian Tribes.

“(c) MEMBERS.—

“(1) APPOINTMENT.—The Commission shall be
composed of 25 members, appointed as follows:

“(A) Ten members of Congress, including
3 from the United States House of Representa-
tives and 2 from the United States Senate, ap-
pointed by their respective majority leaders, and
3 from the United States House of Representa-
tives and 2 from the United States Senate, ap-
pointed by their respective minority leaders, and
who shall be members of the standing commit-
tees of Congress that consider legislation affect-
ing health care to Indians.
“(B) Twelve persons chosen by the Congressional members of the Commission, 1 from each Service Area as currently designated by the Director to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

“(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least one of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

“(D) All those persons chosen by the Congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.
“(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the Congressional members of the Commission.

“(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

“(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 90 days after the date of the enactment of the Indian Health Care Improvement Act Amendments of 2003, and the remaining members of the Commission shall be appointed not later than 60 days following the appointment of the Congressional members.

“(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

“(d) COMPENSATION.—

“(1) CONGRESSIONAL MEMBERS.—Each Congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.
“(2) Other Members.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member’s regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(c) Meetings.—The Commission shall meet at the call of the Chair.

“(f) Quorum.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

“(g) Executive Director; Staff; Facilities.—

“(1) Appointment; Pay.—The Commission shall appoint an executive director of the Commis-
sion. The executive director shall be paid the rate of
basic pay for level V of the Executive Schedule.

“(2) STAFF APPOINTMENT.—With the approval
of the Commission, the executive director may ap­
point such personnel as the executive director deems
appropriate.

“(3) STAFF PAY.—The staff of the Commission
shall be appointed without regard to the provisions
of title 5, United States Code, governing appoint­
ments in the competitive service, and shall be paid
without regard to the provisions of chapter 51 and
subchapter III of chapter 53 of such title (relating
to classification and General Schedule pay rates).

“(4) TEMPORARY SERVICES.—With the ap­
proval of the Commission, the executive director may
procure temporary and intermittent services under
section 3109(b) of title 5, United States Code.

“(5) FACILITIES.—The Administrator of Gen­
eral Services shall locate suitable office space for the
operation of the Commission. The facilities shall
serve as the headquarters of the Commission and
shall include all necessary equipment and incidentals
required for the proper functioning of the Commiss­
ion.
“(h) HEARINGS.—(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count towards the number of regional hearings required by this subsection.

“(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

“(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare and Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.
“(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

“(4) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

“(5) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

“(6) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

“(7) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under
section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

“(8) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

“(9) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

“(i) Authorization of Appropriations.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this section, which sum shall not be deducted from or affect any other appropriation for health care for Indian persons.

“(j) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

“SEC. 816. APPROPRIATIONS; AVAILABILITY.

“Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.
“SEC. 817. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS: QUALIFIED IMMUNITY FOR PARTICIPANTS.

“(a) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

“(b) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

“(1) No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (e).

“(2) A person who reviews or creates medical quality assurance records for any Indian health program or who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in
connection with such records except as provided in this section.

“(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

“(1) Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

“(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform monitoring, required by law, of such program or organization.

“(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

“(C) To a governmental board or agency or to a professional health care society or orga-
nization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization.

“(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian Health Program or Urban Indian Organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

“(E) To an officer, employee, or contractor of any Indian Health Program or Urban Indian Organization who has a need for such record or testimony to perform official duties.

“(F) To a criminal or civil law enforcement agency or instrumentality charged under
applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

“(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

“(2) With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization. Such requirement does not apply to the release of information pursuant to section 552a of title 5.

“(d) DISCLOSURE FOR CERTAIN PURPOSES.—
“(1) Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the results of any Indian Health Program or Urban Indian Organizations’s medical quality assurance programs.

“(2) Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the General Accounting Office if such record pertains to any matter within their respective jurisdictions.

“(e) Prohibition on Disclosure of Record or Testimony.—A person or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

“(f) Exemption from Freedom of Information Act.—Medical quality assurance records described in subsection (a) may not be made available to any person under section 552 of title 5.

“(g) Limitation on Civil Liability.—A person who participates in or provides information to a person or body that reviews or creates medical quality assurance
records described in subsection (a) shall not be civilly liable for such participation or for providing such information if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place.

“(h) Application to Information in Certain Other Records.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient’s medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

“(i) Regulations.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802 of this title.

“(j) Definitions.—In this section:

“(1) The term ‘medical quality assurance program’ means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other re-
view bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

“(2) The term ‘medical quality assurance record’ means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (1) and are produced or compiled by an Indian Health Program or Urban Indian Organization as part of a medical quality assurance program.

“(3) The term ‘health care provider’ means any health care professional, including community health aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.
“SEC. 818. AUTHORIZATION OF APPROPRIATIONS.

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

SEC. 3. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following new section:

“Sec. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).”.

SEC. 4. AMENDMENTS TO MEDICARE PROGRAM.

(a) Expansion of Medicare Payment for All Covered Services Furnished by Indian Health Programs.—

(1) Expansion to all covered services.—

Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended—

(A) by amending the heading to read as follows:

“INDIAN HEALTH PROGRAMS”;

(B) by amending subsection (a) to read as follows:
“(a) An Indian Health Program (as that term is defined in section 4 of the Indian Health Care Improvement Act) shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), with respect to covered items and services it furnishes if (subject to section 408 of such Act) it meets the conditions and requirements for such payments which apply to the furnishing of such items and services under this title.”; and

(C) by striking subsection (e).

(2) **Elimination of Temporary Deeming Provision, Separate Fund Requirement, and Duplicitative Annual Report.**—Such section is amended by striking subsections (b) through (d).

(3) **Reference Correction.**—Subsection (f) of such section is redesignated as subsection (b) and is amended by striking “section 405” and inserting “section 401(d)”.

(b) **Limitation on Charges for Hospital Contract Health Services Provided to Indians by Medicare Participating Hospitals.**—

(1) **In General.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (R), by striking “and” at the end;
(B) in subparagraph (S), by striking the period and inserting ‘‘, and’’; and

(C) by adding at the end the following new subparagraph:

“(T) in the case of hospitals and critical access hospitals which furnish services for which payment may be made under this title to be a participating provider—

“(i) under the contract health services program operated by an Indian Health Program (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under and furnished to an individual eligible for such program; and

“(ii) under a program funded by the Indian Health Service and operated by an Urban Indian Organization with respect to the purchase of items and services for an eligible Urban Indian (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603); in accordance with regulations promulgated by the Secretary regarding admission practices,
payment methodology, and rates of payment
(including the acceptance of not more than such
payment rate as payment in full for such items
and services).”.

(2) EFFECTIVE DATE.—The amendments made
by paragraph (1) shall apply as of a date specified
by the Secretary of Health and Human Services (but
in no case later than 6 months after the date of the
enactment of this Act) to medicare participation
agreements in effect (or entered into) on or after
such date.

(c) MEDICARE COVERAGE OF SERVICES OF COMMU-
NITY HEALTH AIDES OR PRACTITIONERS.—

(1) IN GENERAL.—Section 1861 of such Act
(42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)(K)—

(i) in clause (ii), by adding “and” at
the end; and

(ii) by adding at the end the following
new clause:

“(iii) services which would be physicians’ serv-
ices if furnished by a physician (as defined in sub-
section (r)(1)) and which are performed by a com-
munity health aide or practitioner which the aide or
practitioner is legally authorized to perform, and
such services and supplies furnished as incident to
such services as would be covered under subpara-
graph (A) if furnished incident to a physician’s pro-
fessional service but only if no other provider
charges or is paid any amounts with respect to the
professional fee for furnishing of such services (and,
in the case of a telehealth service described in sec-
tion 1834(m), treating services at the originating
site and the distant site as separate services);”;
and

(B) by adding at the end the following new
subsection:

“Community Health Aides or Practitioners

“(ww) The term ‘community health aides or practi-
tioner’ means such an aide or practitioner who has been
certified under the provisions of section 121 of the Indian
Health Care Improvement Act and who only provides serv-
ices as an employee of the Indian Health Service, an In-
dian Tribe, or Tribal Organization.”.

(2) PAYMENT.—

(A) PAYMENT RATE.—Section

1833(a)(1)(O) of such Act (42 U.S.C.
1395l(a)(1)(O)) is amended—

(i) by striking “or” before “(ii)”; and

(ii) by adding at the end the fol-
lowing: “or (iii) in the case of services of
a community health aide or practitioner,
the lesser of the actual charge or 80 per-
cent of the fee schedule amount provided
under section 1848,”.

(B) LIMITATION ON BALANCE BILLING.—
Section 1842(b)(18)(C) of such Act (42 U.S.C.
1395u(b)(18)(C)) is amended by adding at the
end the following new clause:
“(vii) A community health aide or practi-
tioner.”.

(3) EFFECTIVE DATE.—The amendments made
by this subsection shall apply to services furnished
on or after January 1, 2004.

(d) CONTINUATION OF SPECIAL TREATMENT FOR
COLLABORATIVE ARRANGEMENTS BETWEEN INDIAN
HEALTH PROGRAMS AND HOSPITAL OUTPATIENT DE-
PARTMENTS.—Section 1833(t)(13) of the Social Security
Act (42 U.S.C. 1395l(t)(13)) is amended by adding at the
end the following new subparagraph:
“(B) EXTENSION OF TREATMENT OF cer-
tain collaborative arrangements.—With
respect to the treatment under this subsection
of collaborative arrangements between a health
program operated by the Indian Health Service,
an Indian Tribe, or Tribal Organization and a
hospital operated by such Service or such an
Indian Tribe or Tribal Organization, the Sec­
retary shall reinstate treatment (as in effect on
January 1, 2000) and extend it to such collabo­
rate arrangements regardless of when they
were entered into.”.

(e) COVERAGE OF VISITING NURSE SERVICES OF
TRIBAL CLINICS.—

(1) IN GENERAL.—Section 1861(aa)(1) of the
Social Security Act (42 U.S.C. 1395x(aa)(1)) is
amended by adding at the end the following:
“For purposes of applying subparagraph (C) (relating to
visiting nurse services), an ambulatory care clinic or other
outpatient program of the Indian Health Service or of an
Indian Tribe or a Tribal Organization (as such terms are
defined in section 4 of the Indian Health Care Improve­
ment Act) shall be treated as if it were a rural health clinic
located in an area described in such subparagraph, and
nursing care and supplies described in such subparagraph
and furnished to an individual as an outpatient of such
a tribal clinic or program shall be reimbursable under this
title using the methodology specified in section 4(f) of the
Indian Health Care Improvement Act Amendments of
2003, and, for purposes of this sentence, any reference
in such subparagraph (C) to a licensed practical nurse is
also deemed to include a reference to a home health aide.”.

(2) Effective date.—The amendment made
by paragraph (1) shall apply services furnished on or

(f) Medicare Payment for Outpatient Clinics.—

(1) In general.—Notwithstanding any other
provision of law, for purposes of determining the
rate of reimbursement under title XVIII of the So-
cial Security Act, any outpatient or ambulatory care
clinic (whether freestanding or provider-based) oper-
ated by the Indian Health Service, by an Indian
Tribe, or by a Tribal Organization (as such terms
are defined for purposes of the Indian Health Care
Improvement Act) shall, upon the election of such
clinic, be reimbursed on the same basis as if such
clinic were a hospital outpatient department of the
Indian Health Service.

(2) Effective date.—Paragraph (1) shall
apply to payment for services furnished on or after

(g) Review of Medicare and Medicaid Payment
Systems.—

(1) Study.—
(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a review of the extent to which the payment methodologies applicable under titles XVIII and XIX of the Social Security Act (including under section 1880 of such Act, as amended by this section, section 1911 of such Act, as amended by section 5(a), and including payment methodologies in effect at the time the review is undertaken and payment methodologies effected under this section or section 5) take into account the unique or special circumstances of the provision of covered services to Indians by the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act).

(B) MATTERS CONSIDERED.—In particular, the Secretary shall review the sufficiency of the payment amounts under such methodologies in assuring access to care and payment rates consistent with the payment rates for most favored providers.

(C) CONSULTATION.—In conducting the study, the Secretary shall consult with the In-
(2) REPORT.—Not later than 2 years after the date of implementation of the amendments made by subsection (a) (or, if later, the date of implementation of the amendments made by section 5(a)), the Secretary shall submit to Congress a report on the review under paragraph (1). Such report shall include recommendations for such adjustments to such payment methodologies as may be necessary to assure that payment amounts under the medicare and medicaid programs to such Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations are sufficient to provide access to quality care.

(3) RETENTION OF CURRENT PAYMENT METHODOLOGY.—Notwithstanding any other provision of law, the Secretary shall retain the all-inclusive payment methodology for encounter rates for the Indian Health Service, Indian Tribes, and Tribal Organizations under titles XVIII and XIX of the Social Security Act unless the use of such methodology is expressly prohibited or otherwise superseded by Act of Congress.
SEC. 5. AMENDMENTS TO MEDICAID PROGRAM AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

(a) Expansion of Medicaid Payment for All Covered Services Furnished by Indian Health Programs.—

(1) Expansion to all covered services.—

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended—

(A) by amending the heading to read as follows:

“INDIAN HEALTH PROGRAMS”; and

(B) by amending subsection (a) to read as follows:

“(a) The Indian Health Service and an Indian Tribe or Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) shall be eligible for reimbursement for medical assistance provided under a State plan with respect to covered items and services it furnishes if it meets all the conditions and requirements which are applicable generally to the furnishing of such items and services under this title.”.

(2) Elimination of temporary deeming provision—Such section is amended by striking subsection (b).
(3) Revision of authority to enter into agreements.—Subsection (c) of such section is redesignated as subsection (b) and is amended to read as follows:

“(b) The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act), directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe or Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan.”.

(4) Reference correction.—Subsection (d) of such section is redesignated as subsection (c) and is amended by striking “section 405” and inserting “section 401(d)”.

(b) Seeking advice from 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 new paragraph:

“(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian Tribes, Tribal Organizations, or Urban Indian Organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) providing health care in the State for which medical assistance is available, provide for the establishment and maintenance of the advisory process described in section 409(b) of such Act.”.

(e) SCHIP TREATMENT OF INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—

Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting “or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)” after “Service”.

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