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

IN THE SENATE OF THE UNITED STATES

December 8, 2006

Mr. Mccain (for himself, Mr. Dorgan, Mr. Enzi, and Ms. Murkowski) intro-
duced the following bill; which was read twice and referred to the Com-
mittee on Indian Affairs

A BILL

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

1 Be it enacted by the Senate and House of Representa-
tives of the United States of America in Congress assembled,

2 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

3 (a) SHORT TITLE.—This Act may be cited as the

4 “Indian Health Care Improvement Act Amendments of

5 2006”.

6 (b) TABLE OF CONTENTS.—The table of contents of

7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS TO INDIAN LAWS
Sec. 101. Indian Health Care Improvement Act amended.
Sec. 102. Soboba sanitation facilities.
Sec. 103. Native American Health and Wellness Foundation.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

Sec. 201. Expansion of payments under Medicare, Medicaid, and SCHIP for all covered services furnished by Indian Health Programs.
Sec. 202. Increased outreach to Indians under Medicaid and SCHIP and improved cooperation in the provision of items and services to Indians under Social Security Act health benefit programs.
Sec. 203. Additional provisions to increase outreach to, and enrollment of, Indians in SCHIP and Medicaid.
Sec. 204. Premiums and cost sharing protections under Medicaid, eligibility determinations under Medicaid and SCHIP, and protection of certain Indian property from Medicaid estate recovery.
Sec. 205. Nondiscrimination in qualifications for payment for services under Federal health care programs.
Sec. 206. Consultation on Medicaid, SCHIP, and other health care programs funded under the Social Security Act involving Indian Health Programs and Urban Indian Organizations.
Sec. 207. Exclusion waiver authority for affected Indian Health Programs and safe harbor transactions under the Social Security Act.
Sec. 208. Rules applicable under Medicaid and SCHIP to managed care entities with respect to Indian enrollees and Indian health care providers and Indian managed care entities.
Sec. 209. Annual report on Indians served by Social Security Act health benefit programs.

TITLE I—AMENDMENTS TO INDIAN LAWS

SEC. 101. INDIAN HEALTH CARE IMPROVEMENT ACT AMENDED.

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:

1  TITLE I—AMENDMENTS TO INDIAN LAWS
2  SEC. 101. INDIAN HEALTH CARE IMPROVEMENT ACT
3  AMENDED.
5  The Indian Health Care Improvement Act (25 U.S.C.
6  1601 et seq.) is amended to read as follows:
7  “SECTION 1. SHORT TITLE; TABLE OF CONTENTS.
8  ““(a) SHORT TITLE.—This Act may be cited as the
9  ‘Indian Health Care Improvement Act’.
10  ““(b) TABLE OF CONTENTS.—The table of contents
11  for this Act is as follows:

"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. Scholarship programs for Indian Tribes.
“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.
“Sec. 122. Tribal Health Program administration.
“Sec. 123. Health professional chronic shortage demonstration programs.
“Sec. 124. National Health Service Corps.
“Sec. 125. Substance abuse counselor educational curricula demonstration programs.
“Sec. 126. Behavioral health training and community education programs.

“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 and South Dakota as 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.

“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 non-Service 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. Study on 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.

“TITLE IV—ACCESS TO HEALTH SERVICES

“Sec. 401. Treatment of payments under Social Security Act health benefits programs.
“Sec. 402. Grants to and contracts with the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs.
“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 under Federal health care programs in qualifications for reimbursement for services.
“Sec. 409. Consultation.
“Sec. 410. State Children’s Health Insurance Program (SCHIP).
“Sec. 411. Exclusion waiver authority for affected Indian Health Programs and safe harbor transactions under the Social Security Act.
“Sec. 412. Premium and cost sharing protections and eligibility determinations under Medicaid and SCHIP and protection of certain Indian property from Medicaid estate recovery.
“Sec. 413. Treatment under Medicaid and SCHIP managed care.
"Sec. 414. Navajo Nation Medicaid Agency feasibility study.
"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. Division 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. Urban youth treatment center demonstration.
"Sec. 516. Grants for diabetes prevention, treatment, and control.
"Sec. 517. Community Health Representatives.
"Sec. 518. Effective date.
"Sec. 519. Eligibility for services.
"Sec. 520. Authorization of appropriations.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"Sec. 701. Behavioral health prevention and treatment services.
"Sec. 702. 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. Indian youth telemental health demonstration project.
"Sec. 709. Inpatient and community-based mental health facilities design, construction, and staffing.
"Sec. 710. Training and community education.
"Sec. 711. Behavioral health program.
"Sec. 712. Fetal alcohol disorder programs.
"Sec. 713. Child sexual abuse and prevention treatment programs.
"Sec. 714. Behavioral health research.
"Sec. 715. Definitions.
"Sec. 716. Authorization of appropriations.

"TITLE VIII—MISCELLANEOUS"
"Sec. 801. Reports.
"Sec. 802. Regulations.
"Sec. 803. Plan of implementation.
"Sec. 804. Availability of funds.
"Sec. 805. Limitations.
"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. Severability provisions.
"Sec. 814. Establishment of National Bipartisan Commission on Indian Health Care.
"Sec. 815. Appropriations; availability.
"Sec. 816. Authorization of appropriations.

1 "SEC. 2. FINDINGS.

2 "Congress makes the following findings:

3 "(1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people.

4 "(2) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

5 "(3) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.
“(4) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

“SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

“Congress 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 successor objectives;

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

“(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;
“(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

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

“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)(A) 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.
“(B) The term ‘behavioral health’ includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

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

“(5) The term ‘community college’ means—

“(A) a tribal college or university, or

“(B) a junior or community college.

“(6) 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.

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

“(8) The term ‘Director’ means the Director of the Service.

“(9) The term ‘disease prevention’ means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—
“(A) controlling—

“(i) the development of diabetes;
“(ii) high blood pressure;
“(iii) infectious agents;
“(iv) injuries;
“(v) occupational hazards and disabilities;
“(vi) sexually transmittable diseases;
and
“(vii) toxic agents; and

“(B) providing—

“(i) fluoridation of water; and
“(ii) immunizations.

“(10) The term ‘health profession’ means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, and any other health profession.

“(11) The term ‘health promotion’ means—
“(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

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

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

“(D) making available safe water and sanitary facilities;

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

“(F) promoting culturally competent care; and

“(G) providing adequate and appropriate programs, which may include—

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

“(ii) community health;

“(iii) community safety;

“(iv) consumer health education;

“(v) diet and nutrition;
“(vi) immunization and other prevention of communicable diseases, including HIV/AIDS;
“(vii) environmental health;
“(viii) exercise and physical fitness;
“(ix) avoidance of fetal alcohol disorders;
“(x) first aid and CPR education;
“(xi) human growth and development;
“(xii) injury prevention and personal safety;
“(xiii) behavioral health;
“(xiv) monitoring of disease indicators between health care provider visits, through appropriate means, including Internet-based health care management systems;
“(xv) personal health and wellness practices;
“(xvi) personal capacity building;
“(xvii) prenatal, pregnancy, and infant care;
“(xviii) psychological well-being;
“(xix) safe and adequate water;
“(xx) healthy work environments;
“(xxi) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

“(xxii) stress control;

“(xxiii) substance abuse;

“(xxiv) sanitary facilities;

“(xxv) sudden infant death syndrome prevention;

“(xxvi) tobacco use cessation and reduction;

“(xxvii) violence prevention; and

“(xxviii) 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).

“(12) The term ‘Indian’, unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 806, except that, for the purpose of sections 102 and 103, the term also means any individual who—

“(A)(i) irrespective of whether the individual lives on or near a reservation, is a mem-
ber of a tribe, band, or other organized group
of Indians, including those tribes, bands, or
groups terminated since 1940 and those recog-
nized now or in the future by the State in
which they reside; or

“(ii) is a descendant, in the first or second
degree, of any such member;

“(B) is an Eskimo or Aleut or other Alas-
ka Native;

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

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

“(13) The term ‘Indian Health Program’
means—

“(A) any health program administered di-
rectly by the Service;

“(B) any Tribal Health Program; or

“(C) any Indian Tribe or Tribal Organiza-
tion to which the Secretary provides funding
pursuant to section 23 of the Act of June 25,
1910 (25 U.S.C. 47) (commonly known as the
‘Buy Indian Act’).
“(14) The term ‘Indian Tribe’ has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

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

“(16) 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.).

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

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

“(19) The term ‘Service Area’ means the geographical area served by each Area Office.

“(20) 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.
“(21) The term ‘telehealth’ has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

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

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

“(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 contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

“(25) The term ‘Tribal Organization’ has the meaning given the term in the Indian Self-Deter-
mination and Education Assistance Act (25 U.S.C. 450 et seq.).

“(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 of this Act, 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 Alaska 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 grants to public or nonprofit private health or educational entities, Tribal Health Programs, or Urban Indian Organizations to assist such entities in meeting the costs of—

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

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

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

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

“(3) establishing other programs which the 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) Grants.—

“(1) Application.—The Secretary shall not make a grant under this section unless 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 grants; payment.—The amount of a grant 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, grants shall be for 3 years, as provided in regulations issued pursuant to this Act.

“Sec. 103. Health Professions Preparatory Scholarship Program for Indians.

“(a) Scholarships authorized.—The Secretary, acting through the Service, shall provide scholarship grants 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.—Scholarship grants 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 appli-
cant 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 scholarship grants
to Indians who are enrolled full or part time in ac-
credited schools pursuing courses of study in the
health professions. Such scholarships shall be des-
ignated Indian Health Scholarships and shall be
made in accordance with section 338A of the Public
Health Services Act (42 U.S.C. 254l), except as pro-
vided in subsection (b) of this section.
“(2) Determinations by Secretary.—The
Secretary, acting through the Service, shall deter-
mine—
“(A) who shall receive scholarship grants
under subsection (a); and
“(B) the distribution of the scholarships
among health professions on the basis of the
relative needs of Indians for additional service in the health professions.

“(3) Certain delegation not allowed.—
The administration of this section shall be a responsibility of the Director and shall not be delegated in a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

“(b) Active Duty Service Obligation.—

“(1) Obligation met.—The active duty service obligation under a written contract with the Secretary under this section that an Indian has entered into shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice equal to 1 year for each school year for which the participant receives a scholarship award under this part, or 2 years, whichever is greater, by service in 1 or more of the following:

“(A) In an Indian Health Program.

“(B) In a program assisted under title V of this Act.

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

“(D) In a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, the health service provided to Indians would not decrease.

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

“(A) 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 indi-
vidual 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 Secretary;

“(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 Secretary);
or

“(B) 2 years; and

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

“(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 enactment of the Indian Health Care Improvement Act Amendments of 2006 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.—

“(A) IN GENERAL.—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 determines that—

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

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

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

“(B) FACTORS FOR CONSIDERATION.—Be-
fore waiving or suspending an obligation of
service or payment under subparagraph (A), the
Secretary shall consult with the affected Area
Office, Indian Tribes, Tribal Organizations, or
Urban Indian Organizations, and may take into
consideration whether the obligation may be
satisfied in a teaching capacity at a tribal col-
lege or university nursing program under sub-
section (b)(1)(D).

“(5) EXTREME HARDSHIP.—Notwithstanding
any other provision of law, in any case of extreme
hardship or for other good cause shown, the Sec-
retary 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 pay-
ment may be released by a discharge in bankruptcy
under title 11, United States Code, unless that dis-
charge 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 PRO-
GRAM.

"(a) GRANTS AUTHORIZED.—The Secretary, acting
through the Service, shall make grants of not more than
$300,000 to each of 9 colleges and universities for the pur-
pose of developing and maintaining Indian psychology ca-
reer recruitment programs as a means of encouraging In-
dians to enter the behavioral health field. These programs
shall be located at various locations throughout the coun-
try 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 sub-
section (a) to develop and maintain a program at the Uni-
versity of North Dakota to be known as the ‘Quentin N.
Burdick American Indians Into Psychology Program’.
Such program shall, to the maximum extent feasible, co-
ordinate with the Quentin N. Burdick Indian Health Pro-
grams 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 grants 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 af-
iliated 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 sup-
port 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 de-
scribed in subsection (d)(4) that is funded under this sec-
tion. Such obligation shall be met by service—

“(1) in an Indian Health Program;

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

“(3) in the private practice of psychology if, as
determined by the Secretary, in accordance with
guidelines promulgated by the Secretary, such prac-
tice is situated in a physician or other health profes-
sional shortage area and addresses the health care
needs of a substantial number of Indians.
“(f) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $2,700,000 for each of fiscal years 2007 through 2016.

“SEC. 106. SCHOLARSHIP PROGRAMS FOR INDIAN TRIBES.

“(a) In General.—

“(1) Grants Authorized.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

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

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

“(b) Requirements.—

“(1) In General.—A Tribal Health Program receiving a grant under subsection (a) shall provide scholarships to Indians in accordance with the requirements of this section.

“(2) Costs.—With respect to costs of providing any scholarship pursuant to subsection (a)—
“(A) 80 percent of the costs of the scholarship shall be paid from the funds made available pursuant to subsection (a)(1) provided to the Tribal Health Program; and

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

“(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in 1 of the health professions contemplated by this Act.

“(d) CONTRACT.—

“(1) IN GENERAL.—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.

“(2) REQUIREMENTS.—Such contract shall—

“(A) 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—

“(i) 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

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

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

“(i) may only be expended for—

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

“(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B)), with such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and not to 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
“(ii) 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 clause
(i);
“(C) require the recipient of such scholar-
ship to maintain an acceptable level of academic
standing as determined by the educational insti-
tution in accordance with regulations issued
pursuant to this Act; and
“(D) require the recipient of such scholar-
ship to meet the educational and licensure re-
quirements appropriate to each health profes-
sion.
“(3) Service in other service areas.—The
copyrighted work of the United States Government
and Secretary approve and services are not dimin-
ished to Indians in the Service Area where the Trib-
al Health Program providing the scholarship is lo-
cated.
“(e) Breach of contract.—
“(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under subsection (d) shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

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

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

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

“(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.
“(2) Other breaches.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual’s service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

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

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

“(f) Relation to Social Security Act.—The recipient of a scholarship under this section shall agree, in providing health care pursuant to the requirements herein—

“(1) not to discriminate against an individual seeking care on the basis of the ability of the indi-
vidual to pay for such care or on the basis that pay-
ment for such care will be made pursuant to a pro-
gram established in title XVIII of the Social Secu-
rity 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 individ-
uals entitled to medical assistance or child health as-
sistance, 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.

“SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

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

“(b) NOT COUNTED TOWARD ACTIVE DUTY SERVICE OBLIGATION.—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 personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable
to the salary he or she would receive if he or she were
employed in the competitive system. Any individual so 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 scholarship and stipend re-
cipients under sections 104, 105, 106, and 115 and health
professionals, including community health representatives
and emergency medical technicians, to join or continue in
an Indian Health Program and to provide their services
in the rural and remote areas where a significant portion
of Indians reside, the Secretary, acting through the Serv-
ice, may—

“(1) provide programs or allowances to transi-
tion into an Indian Health Program, including li-
censing, board or certification examination assist-
ance, and technical assistance in fulfilling service ob-
ligations under sections 104, 105, 106, and 115; and

“(2) provide programs or allowances to health
professionals employed in an Indian Health Program
to enable them for a period of time each year pre-
scribed by regulation of the Secretary to take leave
of their duty stations for professional consultation,
management, leadership, and refresher training
courses.
“SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

“(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, 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
“(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)(c)(i) of the Public Health Service Act (42 U.S.C. 254d–1(b)(1)(c)(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 serv-
vice as a commissioned officer in the Regular or Re-
serve Corps of the Public Health Service or a civil-
ian 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 aver-
age individual applying to participate in the Loan
Repayment Program.

“(3) TIMELY AVAILABILITY OF FORMS.—The
Secretary shall make such application forms, con-
tract forms, and other information available to indi-
viduals desiring to participate in the Loan Repay-
ment 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 an Indian 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 deter-
mined under regulations of the
Secretary by the educational in-
stitution 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 In-
dian Health Program or Urban In-
dian Organization to which the indi-
vidual may be assigned by the Sec-
retary;

“(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 obliga-
tion of the United States arising out of a con-
tract entered into under this section and any
obligation of the individual which is conditioned
thereon is contingent upon funds being appro-
priated 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 indi-
vidual, 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 sub-
section (e)(1), of the individual’s participation in the
Loan Repayment Program, including extensions re-
sulting in an aggregate period of obligated service in
excess of 4 years; or

“(2) the Secretary’s disapproving an individ-
ual’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) Reimbursements for tax liability.—
For the purpose of providing reimbursements for tax
liability resulting from a payment under paragraph
(2) on behalf of an individual, the Secretary—

“(A) in addition to such payments, may
make payments to the individual in an amount
equal to not less than 20 percent and not more
than 39 percent of the total amount of loan re-
payments made for the taxable year involved;
and

“(B) may make such additional payments
as the Secretary determines to be appropriate
with respect to such purpose.

“(5) 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 af-
fecting the Department while those individuals are under-
going academic training.
“(i) Recruitment.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other 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 individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the 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 subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

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

“(5) RECOVERY OF DELINQUENCY.—

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

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

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

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

“(m) W AIVER OR S USPENSION OF OBLIGATION.—
“(1) I N 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) C ANCELED UPON DEATH.—Any obligation
of an individual under the Loan Repayment Pro-
gram for service or payment of damages shall be
canceled upon the death of the individual.

“(3) H ARDSHIP 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 the 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 sections 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 col-
lected 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 program 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 professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 104, 106, or 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 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 1 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, on a competitive basis, 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 par-
ticipates 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 indi-
vidual fails to complete such obligated service, the indi-
vidual shall be liable to the United States for the period
of service remaining. In such event, with respect to indi-
viduals entering the program after the date of enactment
of the Indian Health Care Improvement Act Amendments
of 2006, the United States shall be entitled to recover
from such individual an amount to be determined in ac-
cordance with the formula specified in subsection (l) of
section 110 in the manner provided for in such subsection.

“(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 sub-
section (a) may be used for 1 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 a grant 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.

“(5) Programs conducted by tribal colleges and universities.

“(e) QUENTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide 1 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, co-ordinate 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 assistance 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 and Education Assistance Act (25 U.S.C. 450 et seq.) (including programs under agreements with the Bureau of Indian Affairs);

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

“(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; or

“(5) in a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, health services provided to Indians would not decrease.

“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 1 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 program 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 establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on or near a reservation or in an Indian Health Program.

“(2) Amount of grants.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $250,000.

“(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 that 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 diploma 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 community college has entered into the agreement required under subsection (b)(2)(C).

“(c) PRIORITY.—Where the requirements of subsection (b) are met, grant award priority shall be provided 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 2 years of employment with an Indian Health Program or Urban Indian Organization; or
“(B) completed any service obligations in-
curred as a requirement of—

“(i) any Federal scholarship program;
or

“(ii) any Federal education loan re-
payment 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 an-
nual 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 employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines is—

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

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

“SEC. 120. NURSING RESIDENCY PROGRAM.

“(a) Establishment of Program.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian 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 Organization 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 or certifications in nursing and public health.
“(b) Service Obligation.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or Urban Indian Organization for a period of obligated service equal to 1 year for every year that nonprofessional employee (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicals), or 2 years for every year that professional nurse (associate degree and bachelor-prepared registered nurses), participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

“Sec. 121. Community Health Aide Program.

“(a) General Purposes of Program.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

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

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

“(b) SPECIFIC PROGRAM REQUIREMENTS.—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, emer-
gency 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;

“(6) develop a system under which the work of community health aides and community health prac-
tioners is reviewed and evaluated to assure the pro-
vision of quality health care, health promotion, and
disease prevention services; and

“(7) ensure that pulpal therapy (not including
pulpotomies on deciduous teeth) or extraction of
adult teeth can be performed by a dental health aide
therapist only after consultation with a licensed den-
tist who determines that the procedure is a medical
emergency that cannot be resolved with palliative
treatment, and further that dental health aide ther­
pists are strictly prohibited from performing all
other oral or jaw surgeries, provided that uncompli-
cated extractions shall not be considered oral sur-
gery under this section.

“(c) PROGRAM REVIEW.—

“(1) NEUTRAL PANEL.—

“(A) ESTABLISHMENT.—The Secretary,
acting through the Service, shall establish a
neutral panel to carry out the study under
paragraph (2).

“(B) MEMBERSHIP.—Members of the neu-
tral panel shall be appointed by the Secretary
from among clinicians, economists, community
practitioners, oral epidemiologists, and Alaska
Natives.
“(2) Study.—

“(A) In general.—The neutral panel established under paragraph (1) shall conduct a study of the dental health aide therapist services provided by the Community Health Aide Program under this section to ensure that the quality of care provided through those services is adequate and appropriate.

“(B) Parameters of study.—The Secretary, in consultation with interested parties, including professional dental organizations, shall develop the parameters of the study.

“(C) Inclusions.—The study shall include a determination by the neutral panel with respect to—

“(i) the ability of the dental health aide therapist services under this section to address the dental care needs of Alaska Natives;

“(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and
“(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

“(D) CONSULTATION.—In carrying out the study under this paragraph, the neutral panel shall consult with Alaska Tribal Organizations with respect to the adequacy and accuracy of the study.

“(3) REPORT.—The neutral panel shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Resources of the House of Representatives a report describing the results of the study under paragraph (2), including a description of—

“(A) any determination of the neutral panel under paragraph (2)(C); and

“(B) any comments received from an Alaska Tribal Organization under paragraph (2)(D).

“(d) NATIONALIZATION OF PROGRAM.—

“(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary, acting through the Service, may establish a national Community Health Aide Program in accordance with the program under this
section, as the Secretary determines to be appropriate.

“(2) EXCEPTION.—The national Community Health Aide Program under paragraph (1) shall not include dental health aide therapist services.

“(3) REQUIREMENT.—In establishing a national program under paragraph (1), the Secretary shall not reduce the amount of funds provided for the Community Health Aide Program described in subsections (a) and (b).

“SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

“The Secretary, acting through the Service, shall, by contract 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. NATIONAL HEALTH SERVICE CORPS.

“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, has ensured that the Indians receiving services from such member will experience no reduction in services.
“SEC. 125. SUBSTANCE ABUSE COUNSELOR EDUCATIONAL CURRICULA DEMONSTRATION PROGRAMS.

“(a) CONTRACTS AND GRANTS.—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 3 years. Such contract or grant may be renewed for an additional 2-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 enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary, after consultation with Indian Tribes and administrators of tribal colleges and universities and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including
applications for renewals of funding) under this section. Such criteria shall ensure that demonstration programs established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

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

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

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

"(1) Classroom education.

"(2) Clinical work experience.

"(3) Continuing education workshops.

"SEC. 126. BEHAVIORAL 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 sub-
section (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 re-
gard to the funding source), and Urban Indian Or-
ganizations.

“(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 contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

“(2) POSITION SPECIFIC TRAINING CRITERIA.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

“(d) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or Urban
Indian Organization, or assist the Indian Tribe, Tribal Organization, or Urban Indian Organization to develop and implement, a program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

“(e) **Plan.**—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’).
“SEC. 127. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 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 (25 U.S.C. 450 et seq.), 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, including the use of telehealth and telemedicine when appropriate;

“(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 inpatient care, outpatient care (including audiology, clinical eye, and vision care), primary care, secondary and tertiary care, and long-term care.

“(B) Preventive health, including mammography and other cancer screening in accordance with section 207.

“(C) Dental care.

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

“(E) Emergency medical services.

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

“(G) Injury prevention programs.

“(H) Home health care.

“(I) Community health representatives.

“(J) Maintenance and improvement.
“(b) No Offset or Limitation.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act of November 2, 1921 (25 U.S.C. 13) (commonly 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 Organizations. 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 Service 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 responsibilities 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 determin-
mination of the extent of the health status and re-
source deficiency of such Indian Tribe or Tribal Or-
ganization.

“(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 enactment of the Indian Health
Care Improvement Act Amendments of 2006, the Sec-
retary 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-
Indian Tribes served by the Service or a Tribal Health Program; and

“(4) an estimate of—

“(A) the amount of health service funds appropriated under the authority of this Act, 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 Organizations.

“(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the ‘Indian Health Care Improvement Fund’.

“SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

“(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter 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 administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.
“(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 and Education Assistance Act (25 U.S.C. 450
et seq.), nor shall CHEF funds be allocated, apportioned,
or delegated on an Area Office, Service Unit, or other
similar basis.

“(d) REGULATIONS.—The Secretary shall promul-
gate regulations consistent with the provisions of this sec-
tion to—

“(1) establish a definition of disasters and cata-
strophic 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 el-
igible 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 es-

“(A) the 2000 level of $19,000; and

“(B) for any subsequent year, not less
than the threshold cost of the previous year in-
creased by the percentage increase in the med-
ical care expenditure category of the consumer
price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

“(3) establish a procedure for the reimbursement of the portion of the costs that exceeds such threshold cost incurred by—

“(A) 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) (commonly 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 catastrophic illness the cost of which was paid from CHEF.

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

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

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

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

“(b) Provision of Services.—The Secretary, acting 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 the report which is required to be submitted to Congress under section 801 an evaluation of—
“(1) the health promotion and disease prevention needs of Indians;

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

“(3) the internal capacity of the Service and Tribal Health Programs to meet such needs; and

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

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

“(a) Determinations Regarding Diabetes.—The Secretary, acting through the Service, and in consultation with Indian Tribes and Tribal Organizations, shall determine—

“(1) by Indian Tribe and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

“(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effective ongoing monitoring of disease indicators) each Service Unit should take to reduce the incidence of, and prevent, treat, and con-
trol the complications resulting from, diabetes among Indian Tribes within that Service Unit.

“(b) DIABETES SCREENING.—To the extent medically 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 and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a Tribal Health Program and may be conducted through appropriate Internet-based health care management programs.

“(c) DIABETES PROJECTS.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian Tribes. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of...
2006 and for projects which are added and funded thereafter.

“(d) Dialysis Programs.—The Secretary is authorized to provide, through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

“(e) Other Duties of the Secretary.—

“(1) In general.—The Secretary shall, to the extent funding is available—

“(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

“(B) 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

“(C) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

“(2) Diabetes Control Officers.—
“(A) IN GENERAL.—The Secretary may es-
tablish and maintain in each Area Office a posi-
tion of diabetes control officer to coordinate and
manage any activity of that Area Office relating
to the prevention, treatment, or control of dia-
abetes to assist the Secretary in carrying out a
program under this section or section 330C of
the Public Health Service Act (42 U.S.C. 254e–
3).

“(B) CERTAIN ACTIVITIES.—Any activity
carried out by a diabetes control officer under
subparagraph (A) that is the subject of a con-
tract or compact under the Indian Self-Deter-
mination and Education Assistance Act (25
U.S.C. 450 et seq.), and any funds made avail-
able to carry out such an activity, shall not be
divisible for purposes of that Act.

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

“(a) LONG-TERM CARE.—Notwithstanding any other
provision of law, the Secretary, acting through the Service,
is authorized to provide directly, or enter into contracts
or compacts under the Indian Self-Determination and
Education Assistance Act (25 U.S.C. 450 et seq.) with
Indian Tribes or Tribal Organizations for, the delivery of
long-term care (including health care services associated
with long-term care) provided in a facility to Indians. Such agreements shall provide for the sharing of staff or other services between the Service or a Tribal Health Program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) by such Indian Tribe or Tribal Organization.

“(b) CONTENTS OF AGREEMENTS.—An agreement 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.

“(a) IN GENERAL.—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.

“(b) COORDINATION OF RESOURCES AND ACTIVITIES.—The Secretary shall also, to the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs.
“(c) Availability.—Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section.

“(d) Use of Funds.—This funding may be used for both clinical and nonclinical research.

“(e) Evaluation and Dissemination.—The Secretary shall periodically—

“(1) evaluate the impact of research conducted under this section; and

“(2) disseminate to Tribal Health Programs information regarding that research as the Secretary determines to be appropriate.

“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 accepted and appropriate national standards, 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 that receives an A or B rating as recommended by the United States Preventive Services Task Force established under section 915(a)(1) of the Public Health Service Act (42 U.S.C. 299b–4(a)(1)). The Secretary shall ensure that screening provided for under this paragraph complies with the recommendations of the Task Force with respect to—

“(A) frequency;

“(B) the population to be served;

“(C) the procedure or technology to be used;

“(D) evidence of effectiveness; and

“(E) other matters that the Secretary determines appropriate.

“SEC. 208. PATIENT TRAVEL COSTS.

“(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term ‘qualified escort’ means—

“(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

“(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or
“(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

“(b) PROVISION OF FUNDS.—The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

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

“(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

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

“SEC. 209. EPIDEMIOLOGY CENTERS.

“(a) ADDITIONAL CENTERS.—In addition to those epidemiology centers already established as of the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, and without reducing the funding
levels for such centers, not later than 180 days after the
date of enactment of the Indian Health Care Improvement
Act Amendments of 2006, the Secretary, acting through
the Service, shall establish 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 Organiza-
tions, 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 Organiza-
tions in the Service Area;

“(2) evaluate existing delivery systems, data
systems, and other systems that impact the improve-
ment 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) GRANTS FOR STUDIES.—The Secretary may make grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct epidemiological studies of Indian communities.
“SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

“(a) Funding for Development of Programs.—

In addition to carrying out any other program for health promotion or disease prevention, the Secretary, acting through the Service, is authorized to award grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop comprehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of Indian and Urban Indian children.

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

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

“(2) Training teachers in comprehensive school health education materials.

“(3) Integrating school-based, community-based, and other public and private health promotion efforts.

“(4) Encouraging healthy, tobacco-free school environments.
“(5) Coordinating school-based health programs with existing services and programs available in the community.

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

“(7) Developing behavioral health wellness programs.

“(8) Developing chronic disease prevention programs.

“(9) Developing substance abuse prevention programs.

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

“(11) Developing activities for the prevention and control 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 grants awarded under this section.

“(e) Development of Program for BIA-Funded Schools.—

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

“(2) Requirements for Programs.—Such programs shall include—

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

“(B) behavioral health wellness programs;

“(C) chronic disease prevention programs;
“(D) substance abuse prevention programs;

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

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

“(3) DUTIES OF THE SECRETARY.—The Secretary of the Interior shall—

“(A) provide training to teachers in comprehensive school health education materials;

“(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 administer a program to provide grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and Urban Indian preadolescent and adolescent youths.

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

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

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

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

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

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

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

“(3) at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance in the implementation of such models.
“(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

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

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

“(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial 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, Tribal Organizations, and Urban Indian Organizations receiving funding under this section are encouraged to coordinate their activities with the Centers for Disease Control and Prevention and State and local health agencies.

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

“(1) may, at the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, provide technical assistance; and

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

(1) hospice care;
(2) assisted living;
(3) long-term care; and
(4) home- and community-based services, in accordance with subsection (c).

(b) Terms and Conditions.—

(1) In general.—The Secretary shall require that any service provided under this section shall be in accordance with such terms and conditions as the Secretary determines to be consistent with accepted and appropriate standards relating to the service, including any licensing term or condition under this Act.

(2) Standards.—

(A) In general.—In accordance with this Act and the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the Secretary may use the standards for
a service provided under this section required
by the State in which the service is provided.

“(B) INDIAN TRIBES.—If a service under
this section is provided by an Indian Tribe or
Tribal Organization pursuant to the Indian
Self-Determination and Education Assistance
Act (25 U.S.C. 450 et seq.), the verification by
the Secretary that the service meets any stand-
ards required by the State in which the service
is or will be provided shall be considered to
meet the terms and conditions required under
this subsection.

“(3) ELIGIBILITY.—The following individuals
shall be eligible to receive long-term care under this
section:

“(A) Individuals who are unable to per-
form a certain number of activities of daily liv-
ing without assistance.

“(B) Individuals with a mental impair-
ment, such as dementia, Alzheimer’s disease, or
another disabling mental illness, who may be
able to perform activities of daily living under
supervision.
“(C) Such other individuals as an applicable Indian Health Program determines to be appropriate.

“(e) 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 services (whether provided by the Service or by an Indian Tribe or Tribal Organization under a contract, grant agreement, or cooperative agreement pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) for which the Secretary has established standards pursuant to subsection (b):

“(A) Home health aide services.

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

“(C) Respite care.

“(D) Adult day care.

“(E) Such other services identified by an Indian Tribe or Tribal Organization for which the Secretary has established standards pursuant to subsection (b).
“(2) The term ‘hospice care’ means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

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

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

“SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

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

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

“(2) an analysis of the potential effect of 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 uranium mining
and milling, uranium mine tailing deposits, nuclear
power plant operation and construction, and nuclear
waste disposal; oil and gas production or transpor-
tation on or near reservations or Indian commu-
nities; 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 enactment of the Indian Health Care Improvement Act Amendments of 2006 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

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

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

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

“(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation or affected by other activities that have had or could have a serious impact upon the health of such individuals; and
“(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

“(c) Submission of Report and Plan to Congress.—The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006. 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 DELIVERY AREA.

“(a) In General.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2016, the State
of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

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

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

“(a) IN GENERAL.—Beginning in fiscal year 2003, the States of North Dakota and 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 North Dakota and South Dakota.

“(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if such curtailment is due to the provision of contract services in such States pursuant to the des-
ignation of such States 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 In-
dian Catastrophic Health Emergency Fund described in
section 202 or from amounts appropriated or otherwise
made available to the California contract health service de-
delivery area for a fiscal year.

“(e) ADVISORY BOARD.—There is established an ad-
visory 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 1⁄2 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, Sac-
ramento, San Francisco, San Mateo, Santa Clara, Kern,
Merced, Monterey, Napa, San Benito, San Joaquin, San
Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ven-
tura, shall be designated as a contract health service deliv-
ery area by the Service for the purpose of providing con-
tract 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 specifi-
cally provided by the Service for such services in those counties.

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

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

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

"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 Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

“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. OFFICE OF INDIAN MEN’S HEALTH.

“(a) ESTABLISHMENT.—The Secretary may establish within the Service an office to be known as the ‘Office of Indian Men’s Health’ (referred to in this section as the ‘Office’).

“(b) DIRECTOR.—

“(1) IN GENERAL.—The Office shall be headed by a director, to be appointed by the Secretary.

“(2) DUTIES.—The director shall coordinate and promote the status of the health of Indian men in the United States.

“(c) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary, acting through the director of the Office, shall submit to Congress a report describing—

“(1) any activity carried out by the director as of the date on which the report is prepared; and

“(2) any finding of the director with respect to the health of Indian men.

“SEC. 226. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 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) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall—

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

“(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any accrediting body recognized by the Secretary for the purposes of the Medicare, Medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act 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—

“(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; and

“(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, envi-
ronmental, or construction safety reasons.

“(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

“(1) IN GENERAL.—

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

“(i) shall be developed in consultation 
with Indian Tribes and Tribal Organiza-
tions;

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

“(iii)(I) may include the lists required 
in paragraph (2)(B)(ii); and

“(II) shall include the methodology re-
quired in paragraph (2)(B)(v); and

“(III) may include such other facili-
ties, and such renovation or expansion 
needs of any health care facility, as the 
Service, Indian Tribes, and Tribal Organi-
zations may identify; and

“(iv) shall provide an opportunity for 
the nomination of planning, design, and 
construction projects by the Service, In-
dian Tribes, and Tribal Organizations for
consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

“(B) Needs of facilities under ISDEAA agreements.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities operated under contracts or compacts in accordance with the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) are fully and equitably integrated into the health care facility priority system.

“(C) Criteria for evaluating needs.—For purposes of this subsection, the Secretary, in evaluating the needs of facilities operated under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall use the criteria used by the Secretary in evaluating the needs of facilities operated directly by the Service.

“(D) Priority of certain projects protected.—The priority of any project estab-
lished under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Act Amendments of 2006 shall not be affected by any change in the construction priority system taking place after that date if the project—

“(i) was identified in the fiscal year 2007 Service budget justification as—

“(I) 1 of the 10 top-priority inpatient projects;

“(II) 1 of the 10 top-priority outpatient projects;

“(III) 1 of the 10 top-priority staff quarters developments; or

“(IV) 1 of the 10 top-priority Youth Regional Treatment Centers;

“(ii) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or

“(iii) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—

“(I) on the initiative of the Sec-
“(II) pursuant to a request of an
Indian Tribe or Tribal Organization.

“(2) Report; contents.—

“(A) Initial comprehensive report.—

“(i) Definitions.—In this subpara-
graph:

“(I) Facilities Appropriation
Advisory Board.—The term ‘Facili-
ties Appropriation Advisory Board’
means the advisory board, comprised
of 12 members representing Indian
tribes and 2 members representing
the Service, established at the discre-
tion of the Director—

“(aa) to provide advice and
recommendations for policies and
procedures of the programs fund-
ed pursuant to facilities appro-
piations; and

“(bb) to address other facili-
ties issues.

“(II) Facilities Needs Assessment
Workgroup.—The term ‘Fa-
cilities Needs Assessment Workgroup’
means the workgroup established at
the discretion of the Director—

“(aa) to review the health

care facilities construction pri-

ority system; and

“(bb) to make recommenda-

tions to the Facilities Appropria-

tion Advisory Board for revising
the priority system.

“(ii) INITIAL REPORT.—

“(I) IN GENERAL.—Not later

than 1 year after the date of enact-

ment of the Indian Health Care Im-

provement Act Amendments of 2006,

the Secretary shall submit to the

Committee on Indian Affairs of the

Senate and the Committee on Re-

sources of the House of Representa-

tives a report that describes the com-

prehensive, national, ranked list of all

health care facilities needs for the

Service, Indian Tribes, and Tribal Or-

ganizations (including inpatient health

care facilities, outpatient health care

facilities, specialized health care facili-
ties (such as for long-term care and alcohol and drug abuse treatment),
wellness centers, staff quarters and hostels associated with health care fa-
cilities, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian Tribes, and Tribal Organizations for the Facilities Needs Assessment Workgroup and the Facilities Approp-
riation Advisory Board.

“(II) INCLUSIONS.—The initial report shall include—

“(aa) the methodology and criteria used by the Service in de-
termining the needs and estab-
lishing the ranking of the facili-
ties needs; and

“(bb) such other information as the Secretary determines to be appropriate.

“(iii) UPDATES OF REPORT.—Begin-
nning in calendar year 2010, the Secretary shall—
“(I) update the report under clause (ii) not less frequently that once every 5 years; and

“(II) include the updated report in the appropriate annual report under subparagraph (B) for submission to Congress under section 801.

“(B) Annual reports.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report which sets forth the following:

“(i) A description of the health care facility priority system of the Service established under paragraph (1).

“(ii) Health care facilities lists, which may include—

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

“(II) the 10 top-priority outpatient health care facilities;

“(III) the 10 top-priority specialized health care facilities (such as long-term care and alcohol and drug abuse treatment);
“(IV) the 10 top-priority staff quarters developments associated with health care facilities; and

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

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

“(iv) The projected cost of such projects.

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

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

“(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, Tribal Organizations, and Urban Indian Organizations for health care facilities (including hostels and staff quarters), including needs for renovation and expansion of existing facilities.
“(d) Review of Methodology Used for Health Facilities Construction Priority System.—

“(1) In general.—Not later than 1 year after the establishment of the priority system under subsection (c)(1)(A), the Comptroller General of the United States shall prepare and finalize a report reviewing the methodologies applied, and the processes followed, by the Service in making each assessment of needs for the list under subsection (c)(2)(A)(ii) and developing the priority system under subsection (c)(1), including a review of—

“(A) the recommendations of the Facilities Appropriation Advisory Board and the Facilities Needs Assessment Workgroup (as those terms are defined in subsection (c)(2)(A)(i));

and

“(B) the relevant criteria used in ranking or prioritizing facilities other than hospitals or clinics.

“(2) Submission to Congress.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

“(A) the Committees on Indian Affairs and Appropriations of the Senate;
“(B) the Committees on Resources and Appropriations of the House of Representatives; and

“(C) the Secretary.

“(e) **FUNDING CONDITION.**—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), 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-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

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

**SEC. 302. SANITATION FACILITIES.**

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

“(1) The provision of sanitation facilities is primarily 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, is authorized to 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 (25 U.S.C.
4101 et seq.) 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 when funds are appropriated, the Secretary shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

“(4) the Secretary of Health and Human Services is authorized to accept from any source, including Federal and State agencies, funds for the purpose of providing sanitation facilities and services and place these funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

“(5) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to meet matching

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or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

“(6) 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;

“(7) 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;

“(8) the Secretary of Health and Human Services shall, by regulation, establish standards applicable to the planning, design, and construction of sanitation facilities funded under this Act; and

“(9) the Secretary of Health and Human Services is authorized to accept payments for goods and services furnished by the Service from appropriate public authorities, nonprofit organizations or agencies, or Indian Tribes, as contributions by that authority, organization, agency, or tribe to agreements made under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), and such payments shall be
credited to the same or subsequent appropriation account as funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

“(d) 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.

“(e) 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.

“(f) Operation, Management, and Maintenance of Facilities.—The Indian Tribe 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 or Tribal Organization 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 as-
sist the Indian Tribe, Tribal Organization, or Indian com-

munity in the resolution of the problem on a short-term
basis through cooperation with the emergency coordinator
or by providing operation, management, and maintenance
service.

“(g) ISDEAA PROGRAM FUNDED ON EQUAL
BASIS.—Tribal Health Programs shall be eligible (on an
equal basis with programs that are administered directly
by the Service) for—

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

“(2) any funds appropriated for the purpose of

providing sanitation facilities.

“(h) REPORT.—

“(1) REQUIRED; CONTENTS.—The Secretary, in
consultation with the Secretary of Housing and
Urban Development, Indian Tribes, Tribal Organiza-
tions, and tribally designated housing entities (as de-
dined in section 4 of the Native American Housing
Assistance and Self-Determination Act of 1996 (25
U.S.C. 4103)) shall submit to the President, for in-
clusion in the 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 and needs;

“(C) the criteria on which the deficiencies and needs will be evaluated;

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

“(E) the amount and most effective use of funds, derived from whatever source, necessary to accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing Assistance and Self-Determination Act (25 U.S.C. 4101 et seq.), and to reduce the identified sanitation deficiency levels of all Indian Tribes and Indian communities to level I sanitation deficiency as defined in paragraph (3)(A); and

“(F) a 10-year plan to provide sanitation facilities to serve existing Indian homes and Indian communities and new and renovated Indian homes.
“(2) 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.

“(3) 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 facilities in order to meet the current needs for domestic sanitation facilities; or

“(iii) the lack of equipment or training by an Indian Tribe, Tribal Organization, or an Indian community to properly operate and maintain the sanitation facilities.

“(C) A level III deficiency exists if a sanitation facility serving an individual, Indian Tribe or Indian community meets 1 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 frequently, requiring major capital improvements to correct the deficiencies; or
“(iii) there is no access to or no approved or permitted solid waste facility available.

“(D) A level IV deficiency exists—

“(i) if a sanitation facility for an individual home, an Indian Tribe, or an Indian community exists but—

“(I) lacks—

“(aa) a safe water supply system; or

“(bb) a waste disposal system;

“(II) contains no piped water or sewer facilities; or

“(III) has become inoperable due to a major component failure; or

“(ii) if only a washteria 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.

“(i) 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, pur-
suant to regulations, 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 subchapter IV of chapter 31 of title 40, United States Code (commonly 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 or compact authorized by the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), 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 NON-SERVICE 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 contract or compact under the Indian
Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), 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 establishing priorities shall be developed through regulations. 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 the 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 Secretary with respect to construction or renovation of Service facilities.

“(d) ADDITIONAL REQUIREMENT FOR EXPANSION.—

In addition to the requirements under subsection (c), for any expansion, the Indian Tribe or Tribal Organization shall provide to the Secretary additional information pursuant to regulations, including additional staffing, equipment, and other costs associated with the expansion.

“(e) 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 ex-

pansion, 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, renova-
tion, or modernization (less the total amount of any funds

provided specifically for such facility under any Federal

program that were expended for such expansion, renov-
tion, or modernization) bore to the value of such facility

at the time of the completion of such expansion, renov-
tion, or modernization.

“SEC. 305. FUNDING FOR THE CONSTRUCTION, EXPANSION,

AND MODERNIZATION OF SMALL AMBULA-

TORY CARE FACILITIES.

“(a) GRANTS.—

“(1) IN GENERAL.—The Secretary, acting

through the Service, shall make grants to Indian

Tribes and Tribal Organizations for the construc-
tion, expansion, or modernization of facilities for the

provision of ambulatory care services to eligible Indi-

ans (and noneligible persons pursuant to subsections

(b)(2) and (e)(1)(C)). A grant made under this sec-
tion 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) Grant agreement required.—A grant 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 grant funds.—

“(1) Allowable uses.—A grant awarded under this section may be used for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

“(A) located apart from a hospital;

“(B) not funded under section 301 or section 307; and

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

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

“(ii) provide annually no fewer than 150 patient visits by eligible Indians and other users who are eligible for services in
such facility in accordance with section 807(e)(2); and

“(iii) provide ambulatory care in a Service Area (specified in the contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) 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(e)(2).

“(2) ADDITIONAL ALLOWABLE USE.—The Secretary may also reserve a portion of the funding provided under this section and use those reserved funds to reduce an outstanding debt incurred by Indian Tribes or Tribal Organizations for the construction, expansion, or modernization of an ambulatory care facility that meets the requirements under paragraph (1). The provisions of this section shall apply, except that such applications for funding under this paragraph shall be considered separately from applications for funding under paragraph (1).

“(3) USE ONLY FOR CERTAIN PORTION OF COSTS.—A grant provided under this section may be used only for the cost of that portion of a construc-
tion, 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 applying for a grant under this section for a health care facility located or to be constructed on an island or when such facility is not located on a road system providing direct access to an inpatient hospital where care is available to the Service population.

“(c) GRANTS.—

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

“(A) adequate financial support will be available for the provision of services at such facility;
“(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

“(C) such facility will, as feasible without diminishing the quality or quantity of services provided to eligible Indians, serve noneligible persons on a cost basis.

“(2) PRIORITY.—In awarding grants 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 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, at any time 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 (25 U.S.C. 450 et seq.) 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, is authorized to enter into construction agreements under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with 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.

“(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 do-
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 promulgate regulations, not later than 1 year after
the date of enactment of the Indian Health Care Improve-
ment Act Amendments of 2006, for the review and ap-
proval of applications submitted under this section.
“(d) CRITERIA.—The Secretary may approve projects
that meet the following criteria:
“(1) There is a need for a new facility or pro-
gram 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.—Subject to section 807, 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 contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), 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 contract or
compact under the Indian Self-Determination and Edu-
cation Assistance Act (25 U.S.C. 450 et seq.) for health
services are fully and equitably integrated into the imple-
mentation of the health care delivery demonstration
projects under this section.

“SEC. 307. LAND TRANSFER.

“Notwithstanding any other provision of law, the Bu-
reau of Indian Affairs and all other agencies and depart-
ments of the United States are authorized to transfer, at
no cost, land and improvements to the Service for the pro-
vision 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 In-
dian 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 and
Education Assistance Act (25 U.S.C. 450j(l)) and regulations thereunder.

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

“(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of establishing a loan fund to provide to Indian Tribes and Tribal Organizations direct loans or guarantees for loans for the construction of health care facilities, including—

“(1) inpatient facilities;
“(2) outpatient facilities;
“(3) staff quarters;
“(4) hostels; and
“(5) specialized care facilities, such as behavioral health and elder care facilities.

“(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

“(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;
“(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs
relating to planning, design, financing, site land de-
velopment, construction, rehabilitation, renovation,
conversion, improvements, medical equipment and
furnishings, and other facility-related costs and cap-
ital purchase (but excluding staffing));

“(3) the cumulative total of the principal of di-
rect loans and loan guarantees, respectively, that
may be outstanding at any 1 time;

“(4) the maximum term of a loan or loan guar-
antee that may be made for a facility from the loan
fund;

“(5) the maximum percentage of funds from
the loan fund that should be allocated for payment
of costs associated with planning and applying for a
loan or loan guarantee;

“(6) whether acceptance by the Secretary of an
assignment of the revenue of an Indian Tribe or
Tribal Organization as security for any direct loan
or loan guarantee from the loan fund would be ap-
propriate;

“(7) whether, in the planning and design of
health facilities under this section, users eligible
under section 807(e) may be included in any projec-
tion of patient population;
“(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

“(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and

“(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

“(c) REPORT.—Not later than September 30, 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources and the Committee on Energy and Commerce of the House of Representatives a report that describes—

“(1) the manner of consultation made as required by subsection (a); and

“(2) the results of the study, including any recommendations of the Secretary based on results of the study.

“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 dem-
onstration projects under which an Indian Tribe or Tribal
Organization shall expend tribal, private, or other avail-
able 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 Organization only if—

“(1) the Secretary first determines that the Indian Tribe or Tribal Organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

“(2) the Indian Tribe or Tribal Organization meets the need criteria determined using the criteria developed under the health care facility priority system under section 301, unless the Secretary determines, pursuant to regulations, that other criteria will result in a more cost-effective and efficient method of facilitating and completing construction of health care facilities.

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

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

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

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

“SEC. 312. LOCATION OF FACILITIES.

“(a) IN GENERAL.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address
unemployment conditions in economically depressed areas,
the Bureau of Indian Affairs and the Service shall give
priority to locating such facilities and projects on Indian
lands, or lands in Alaska owned by any Alaska Native vil-
lage, or village or regional corporation under the Alaska
Native Claims Settlement Act (25 U.S.C. 1601 et seq.),
or any land allotted to any Alaska Native, if requested
by the Indian owner and the Indian Tribe with jurisdiction
over such lands or other lands owned or leased by the In-
dian 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; and

“(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.

“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 trans-
mitted to Congress under section 801, a report which iden-
tifies 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 sup-
port the growth of health care programs.

“(b) MAINTENANCE OF NEWLY CONSTRUCTED
SPACE.—The Secretary, acting through the Service, is au-
thorized 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
health care facility priority system under section 301(c).

“(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 improve-
ment funds for construction of a replacement facility if
the costs of renovation of such facility would exceed a
maximum renovation cost threshold. The maximum ren-
ovation cost threshold shall be determined through the ne-
gotiated 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 contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) 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, provided that the method for establishing such rates be identified according to guidelines (such as OMB Circular A–45) which will ensure that rents shall be collected, that the rents are fair and reasonable, and that the tenants are not treated inequitably relative to other similar quarters, such as for the Bureau of Indian Affairs.

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

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

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

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

“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 a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

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

“(c) ESTABLISHMENT OF STANDARDS.—The Secretary, through the Service, shall establish standards by regulation for the planning, design, and construction of health care facilities serving Indians under this Act.

“SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 to carry out this title.
“TITLE IV—ACCESS TO HEALTH SERVICES

SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

“(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 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.—

“(A) 100 percent pass-through of payments due to facilities.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of the Social Security Act shall be placed...
in a special fund to be held by the Secretary. In making payments from such fund, the Secretary 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 collections, are entitled by reason of a provision of the Social Security Act.

“(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian Tribes being served by the Service Unit, be used for reducing the health resource deficiencies (as determined under section 201(d)) of such Indian Tribes.
“(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a Tribal Health Program upon the election of such 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 by such Program during the period of such election.

“(d) DIRECT BILLING.—

“(1) IN GENERAL.—Subject to complying with the requirements of paragraph (2), a Tribal Health Program may elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under title XVIII or XIX of the Social Security Act or from any other third party payor.

“(2) DIRECT REIMBURSEMENT.—

“(A) USE OF FUNDS.—Each Tribal Health Program making the election 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 subsection (c)(1), but all amounts so reimbursed shall be used by the Tribal Health Program for the pur-
pose of making any improvements in facilities
of the Tribal Health Program that may be nec-
essary to achieve or maintain compliance with
the conditions and requirements applicable gen-
erally to such items and services under the pro-
gram under such title and to provide additional
health care services, improvements in health
care facilities and Tribal Health Programs, any
health care related purpose, or otherwise to
achieve the objectives provided in section 3 of
this Act.

“(B) AUDITS.—The amounts paid to a
Tribal Health Program making the election de-
scribed in paragraph (1) with respect to a pro-
gram under a title of the Social Security Act
shall be subject to all auditing requirements ap-
icable to the program under such title, as well
as all auditing requirements applicable to pro-
grams administered by an Indian Health Pro-
gram. Nothing in the preceding sentence shall
be construed as limiting the application of au-
diting requirements applicable to amounts paid
under title XVIII, XIX, or XXI of the Social
Security Act.
“(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any Tribal Health Program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, shall provide to the Service a list of each provider enrollment number (or other identifier) under which such Program receives such reimbursements or payments.

“(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

“(A) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this subsection, including any agreements with States that may be necessary to provide for direct billing under a program under a title of the Social Security Act.

“(B) COORDINATION OF INFORMATION.—The Service shall provide the Administrator of the Centers for Medicare & Medicaid Services
with copies of the lists submitted to the Service
under paragraph (2)(C), enrollment data re-
garding patients served by the Service (and by
Tribal Health Programs, to the extent such
data is available to the Service), and such other
information as the Administrator may require
for purposes of administering title XVIII, XIX,
or XXI of the Social Security Act.

“(4) WITHDRAWAL FROM PROGRAM.—A Tribal
Health Program that bills directly under the pro-
gram established under this subsection may with-
draw from participation in the same manner and
under the same conditions that an Indian Tribe or
Tribal Organization may retrocede a contracted pro-
gram to the Secretary under the authority of the In-
dian 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 Sec-
retary upon the Secretary’s acceptance of the with-
drawal of participation in this program.

“(5) TERMINATION FOR FAILURE TO COMPLY
WITH REQUIREMENTS.—The Secretary may termi-
nate the participation of a Tribal Health Program or
in the direct billing program established under this
subsection if the Secretary determines that the Program has failed to comply with the requirements of paragraph (2). The Secretary shall provide a Tribal Health Program with notice of a determination that the Program has failed to comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to terminating the Program’s participation in the direct billing program established under this subsection.

“(e) RELATED PROVISIONS UNDER THE SOCIAL SECURITY ACT.—For provisions related to subsections (c) and (d), see sections 1880, 1911, and 2107(e)(1)(D) of the Social Security Act.

“SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

“(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—From funds appropriated to carry out this title in accordance with section 415, the Secretary, acting through the Service, shall make grants to or enter into contracts with Indian Tribes and Tribal Organizations to
assist such Tribes and Tribal Organizations in establishing and administering programs on or near reservations and trust lands to assist individual Indians—

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

“(2) with respect to such programs for which the charging of premiums and cost sharing is not prohibited under such programs, to pay premiums or cost sharing for coverage for such benefits, which may be based on financial need (as determined by the Indian Tribe or Tribes or Tribal Organizations being served based on a schedule of income levels developed or implemented by such Tribe, Tribes, or Tribal Organizations).

“(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 contract 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 for 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 benefits under such programs.

“(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 contracts with Indian Tribes and Tribal Organizations with respect to programs on or near reservations.

“(2) Requirements.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

“(A) consistent with the requirements imposed by the Secretary under subsection (b);

“(B) appropriate to Urban Indian Organizations and Urban Indians; and
“(C) necessary to effect the purposes of this section.

“(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 with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI of the Social Security Act.

“(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements between the Secretary, acting through the Service, and Indian Tribes, Tribal Organizations, and Urban Indian Organization for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and State children’s health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.
“(f) Definition of Premiums and Cost Sharing.—In this section:

“(1) Premium.—The term ‘premium’ includes any enrollment fee or similar charge.

“(2) Cost sharing.—The term ‘cost sharing’ includes any deduction, deductible, copayment, coinsurance, or similar charge.

“SEC. 403. Reimbursement from Certain Third Parties 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 subdivision or local governmental entity of a State) the reasonable expenses incurred and billed by the Secretary, an Indian Tribe, or Tribal Organization in providing health services through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

“(1) such services had been provided by a nongovernmental provider; and
“(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

“(b) LIMITATIONS ON RECOVERIES FROM STATES.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

“(1) workers’ compensation laws; or

“(2) a no-fault automobile accident insurance plan or program.

“(c) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States, an Indian Tribe, or Tribal Organization under subsection (a).

“(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States, an Indian Tribe, or Tribal Organization to enforce the right of recovery provided under this section shall operate to deny to the
injured person the recovery for that portion of the person’s
damage not covered hereunder.

“(e) Enforcement.—

“(1) In general.—The United States, an 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 authoriza-
tion by the governing body of an Indian Tribe for the pe-
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 recov-
ery 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 ex-
pend 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 pre-
vailing plaintiff shall be awarded its reasonable attorneys’
fees and costs of litigation.

“(h) NONAPPLICATION OF CLAIMS FILING REQUIRE-
MENTS.—An insurance company, health maintenance or-
ganization, self-insurance plan, managed care plan, or
other health care plan or program (under the Social Secu-
rit y 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 re-
quired for submission of claims under title XVIII of the
1 Social Security Act or recognized under section 1175 of such Act.

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

“(j) 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.

“(k) 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 Organization, shall be credited to the Service, such Indian Tribe or Tribal Organization, or such Urban Indian Organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

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

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

“(B) This Act, including section 807.

“(C) Public Law 87–693.

“(D) Any other provision of law.

“(b) No Offset of Amounts.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).
"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 (25 U.S.C. 450 et seq.), 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 finan-
cial risks to the entity offering the plan.
“(c) CONSTRUCTION.—Nothing in this section shall
be construed as affecting the use of any amounts not re-
ferred to in subsection (a).

“SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGEN-
cIES.

“(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 De-
partment of Veterans Affairs and the Department of
Defense.
“(2) CONSULTATION BY SECRETARY RE-
QUIRED.—The Secretary may not finalize any ar-
rangement between the Service and a Department
described in paragraph (1) without first consulting
with the Indian Tribes which will be significantly af-
fected 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 Indian Organizations, notwithstanding any Federal, State, or local law to the contrary.

“SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

“(a) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

“(1) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other
requirements for participation as a provider of health care services under the program.

“(2) Satisfaction of state or local licensure or recognition requirements.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health care professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

“(b) Application of exclusion from participation in Federal health care programs.—
“(1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

“(2) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

“(3) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, ‘Federal health care program’ has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)), except that, for purposes of this subsection, such term shall include the health
insurance program under chapter 89 of title 5, United States Code.

“(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).

“SEC. 409. CONSULTATION.

“For provisions related to consultation with representatives of Indian Health Programs and Urban Indian Organizations with respect to the health care programs established under titles XVIII, XIX, and XXI of the Social Security Act, see section 1139(d) of the Social Security Act (42 U.S.C. 1320b–9(d)).

“SEC. 410. STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP).

“For provisions relating to—

“(1) outreach to families of Indian children likely to be eligible for child health assistance under the State children’s health insurance program established under title XXI of the Social Security Act, see sections 2105(c)(2)(C) and 1139(a) of such Act (42 U.S.C. 1397ee(c)(2), 1320b–9); and

“(2) ensuring that child health assistance is provided under such program to targeted low-income
children who are Indians and that payments are made under such program to Indian Health Programs and Urban Indian Organizations operating in the State that provide such assistance, see sections 2102(b)(3)(D) and 2105(c)(6)(B) of such Act (42 U.S.C. 1397bb(b)(3)(D), 1397ee(c)(6)(B)).

“SEC. 411. EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS AND SAFE HARBOR TRANSACTIONS UNDER THE SOCIAL SECURITY ACT.

“For provisions relating to—

“(1) exclusion waiver authority for affected Indian Health Programs under the Social Security Act, see section 1128(k) of the Social Security Act (42 U.S.C. 1320a–7(k)); and

“(2) certain transactions involving Indian Health Programs deemed to be in safe harbors under that Act, see section 1128B(b)(4) of the Social Security Act (42 U.S.C. 1320a–7b(b)(4)).

“SEC. 412. PREMIUM AND COST SHARING PROTECTIONS AND ELIGIBILITY DETERMINATIONS UNDER MEDICAID AND SCHIP AND PROTECTION OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.

“For provisions relating to—
'"(1) premiums or cost sharing protections for Indians furnished items or services directly by Indian Health Programs or through referral under the contract health service under the Medicaid program established under title XIX of the Social Security Act, see sections 1916(j) and 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o(j), 1396o–1(a)(1));

"(2) rules regarding the treatment of certain property for purposes of determining eligibility under such programs, see sections 1902(e)(13) and 2107(e)(1)(B) of such Act (42 U.S.C. 1396a(e)(13), 1397gg(e)(1)(B)); and

"(3) the protection of certain property from estate recovery provisions under the Medicaid program, see section 1917(b)(3)(B) of such Act (42 U.S.C. 1396p(b)(3)(B)).

"SEC. 413. TREATMENT UNDER MEDICAID AND SCHIP MANAGED CARE.

"For provisions relating to the treatment of Indians enrolled in a managed care entity under the Medicaid program under title XIX of the Social Security Act and Indian Health Programs and Urban Indian Organizations that are providers of items or services to such Indian enrollees, see sections 1932(h) and 2107(e)(1)(H) of the Soc-
Sec. 414. Navajo Nation Medicaid Agency Feasibility Study.

(a) Study.—The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act, to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State Medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

(b) Considerations.—In conducting the study, the Secretary shall consider the feasibility of—

(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

(2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and
delivery of medical assistance under title XIX of the 
Social Security Act;

“(3) providing an appropriate level of matching 
funds for Federal medical assistance with respect to 
amounts such entity expends for medical assistance 
for services and related administrative costs; and 

“(4) authorizing the Secretary, at the option of 
the Navajo Nation, to treat the Navajo Nation as a 
State for the purposes of title XIX of the Social Se-
curity Act (relating to the State children’s health in-
surance program) under terms equivalent to those 
described in paragraphs (2) through (4).

“(c) REPORT.—Not later then 3 years after the date 
of enactment of the Indian Health Care Improvement Act 
Amendments of 2006, the Secretary shall submit to the 
Committee on Indian Affairs and Committee on Finance 
of the Senate and the Committee on Resources and Com-
mittee on Energy and Commerce of the House of Rep-
resentatives a report that includes—

“(1) the results of the study under this section;

“(2) a summary of any consultation that oc-
curred between the Secretary and the Navajo Na-
tion, other Indian Tribes, the States of Arizona, 
New Mexico, and Utah, counties which include Nav-
ajo Lands, and other interested parties, in con-
ducting this study;

“(3) projected costs or savings associated with
establishment of such entity, and any estimated im-
pact on services provided as described in this section
in relation to probable costs or savings; and

“(4) legislative actions that would be required
to authorize the establishment of such entity if such
entity is determined by the Secretary to be feasible.

“SEC. 415. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums
as may be necessary for each fiscal year through fiscal
year 2016 to carry out this title.

“TITLE V—HEALTH SERVICES
FOR URBAN INDIANS

“SEC. 501. PURPOSE.

“The purpose of this title is to establish and maintain
programs in Urban Centers to make health services more
accessible and available to Urban Indians.

“SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN IN-
DIAN ORGANIZATIONS.

“Under authority of the Act of November 2, 1921
(25 U.S.C. 13) (commonly known as the ‘Snyder Act’),
the Secretary, acting through the Service, shall enter into
contracts with, or make grants to, Urban Indian Organi-
zations 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 pur-
suant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION
OF HEALTH CARE AND REFERRAL SERVICES.

"(a) REQUIREMENTS FOR GRANTS AND CON-
TRACTS.—Under authority of the Act of November 2,
1921 (25 U.S.C. 13) (commonly known as the ‘Snyder
Act’), the Secretary, acting through the Service, shall
enter into contracts with, and make grants to, Urban In-
dian 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 or-
ganization proposes to serve who are or could be re-
cipients of health care or referral services;
“(2) estimate the current health status of Urban Indians residing in such Urban Center or centers;

“(3) estimate the current health care needs of Urban Indians residing in such Urban Center or centers;

“(4) provide basic health education, including health promotion and disease prevention education, to Urban Indians;

“(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of Urban Indians; and

“(6) where necessary, provide, or enter into contracts for the provision of, health care services for Urban Indians.

“(b) CRITERIA.—The Secretary, acting through the Service, shall, by regulation, prescribe the criteria for selecting Urban Indian Organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

“(1) the extent of unmet health care needs of Urban Indians in the Urban Center or centers involved;
“(2) the size of the Urban Indian population in the Urban Center or centers involved;

“(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title, or under any current public health service project funded in a manner other than pursuant to this title;

“(4) the capability of an Urban Indian Organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

“(5) the satisfactory performance and successful completion by an Urban Indian Organization of other contracts with the Secretary under this title;

“(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an Urban Center or centers; and

“(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

“(c) ACCESS TO HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS.—The Secretary, acting through the Service, shall facilitate access to or provide health pro-
motion and disease prevention services for Urban Indians
through grants made to Urban Indian Organizations ad-
ministering 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 In-
dian Organizations administering contracts entered
into or receiving grants under this section.

“(2) Definition.—For purposes of this sub-
section, the term ‘immunization services’ means
services to provide without charge immunizations
against vaccine-preventable diseases.

“(e) BEHAVIORAL HEALTH SERVICES.—

“(1) Access or services provided.—The
Secretary, acting through the Service, shall facilitate
access to, or provide, behavioral health services for
Urban Indians through grants made to Urban In-
dian Organizations administering contracts entered
into or receiving grants under subsection (a).

“(2) Assessment required.—Except as pro-
vided by paragraph (3)(A), a grant may not be made
under this subsection to an Urban Indian Organi-
tion until that organization has prepared, and the
Service has approved, an assessment of the fol-
lowing:

“(A) The behavioral health needs of the
Urban Indian population concerned.

“(B) The behavioral health services and
other related resources available to that popu-
lation.

“(C) The barriers to obtaining those serv-
ices 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 coordina-
tion 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) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, may enter into contracts with or make grants to Urban Indian Organizations
situated in Urban Centers for which contracts have not
been entered into or grants have not been made under sec-
tion 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 success-
fully 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, the Secretary shall—

“(1) acting through the Service, conduct an annual onsite evaluation of the organization; or
“(2) accept in lieu of such onsite evaluation evidence of the organization’s provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the Medicare program under title XVIII of the Social Security Act.

“(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under this section, the Secretary determines that an Urban Indian Organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with the organization the areas of noncompliance or unsatisfactory performance and modify the contract or grant to prevent future occurrences of noncompliance or unsatisfactory 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 Organization which is situated in the same Urban Center as the Urban Indian Organization whose contract or grant is not renewed under this section.
“(d) Considerations for Renewals.—In determining 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 section 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 and 3131 through 3133 of title 40, United States Code.

“(b) Payments Under Contracts or Grants.—

“(1) In general.—Payments under any contracts or grants pursuant to this title, notwithstanding any term or condition of such contract or grant—

“(A) may be made in a single advance payment 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 a single advance payment; and

“(B) 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.

“(2) SEMIANNUAL AND QUARTERLY PAYMENTS AND REIMBURSEMENTS.—If the Secretary determines under paragraph (1)(A) that an Urban Indian Organization is not capable of administering an entire single advance payment, on request of the Urban Indian Organization, the payments may be made—

“(A) in semiannual or quarterly payments by not later than 30 days after the date on
which the funding period with respect to which
the payments apply begins; or

“(B) by way of reimbursement.

“(c) Revision or Amendment of Contracts.—
Notwithstanding any provision of law to the contrary, the
Secretary may, at the request and consent of an Urban
Indian Organization, revise or amend any contract entered
into by the Secretary with such organization under this
title as necessary to carry out the purposes of this title.

“(d) Fair and Uniform 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.—

“(1) In general.—For each fiscal year during
which an Urban Indian Organization receives or ex-
pends 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:
“(A) In the case of a contract or grant under section 503, recommendations pursuant to section 503(a)(5).

“(B) Information on activities conducted by the organization pursuant to the contract or grant.

“(C) An accounting of the amounts and purpose for which Federal funds were expended.

“(D) A minimum set of data, using uniformly defined elements, as specified by the Secretary after consultation with Urban Indian Organizations.

“(2) HEALTH STATUS AND SERVICES.—

“(A) IN GENERAL.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary, acting through the Service, shall submit to Congress a report evaluating—

“(i) the health status of Urban Indians;

“(ii) the services provided to Indians pursuant to this title; and
“(iii) areas of unmet needs in the delivery of health services to Urban Indians.

“(B) CONSULTATION AND CONTRACTS.—In preparing the report under paragraph (1), the Secretary—

“(i) shall consult with Urban Indian Organizations; and

“(ii) may enter into a contract with a national organization representing Urban Indian Organizations to conduct any aspect of the report.

“(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) LOAN FUND STUDY.—The Secretary, acting through the Service, may carry out a study to determine the feasibility of establishing a loan fund to provide to Urban Indian Organizations direct loans or guarantees for loans for the construction of health care facilities in a manner consistent with section 309.

"SEC. 510. DIVISION OF URBAN INDIAN HEALTH.

"There is established within the Service a Division 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 pursuant to this section based on the criteria established pursuant to subsection (c).

“(e) GRANTS SUBJECT TO CRITERIA.—Any grant 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 and Operating Units in the allocation of resources and coordination of care; and

“(3) continue to meet the requirements and definitions of an Urban Indian Organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).
“SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

“(a) GRANTS AND CONTRACTS.—The Secretary, through the Division of Urban Indian Health, shall make grants or enter into contracts with Urban Indian Organizations, to take effect not later than September 30, 2008, for the administration of Urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as ‘NIAAA’) and transferred to the Service.

“(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 consults, to the greatest extent practicable, with Urban Indian Organizations.

(b) Definition of Consultation.—For purposes of subsection (a), consultation is the open and free exchange of information and opinions which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

SEC. 515. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

(a) Construction and Operation.—The Secretary, acting through the Service, through grant or contract, is authorized to fund the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

(b) Definition of State.—A State described in this subsection is a State in which—

(1) there resides Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting; and
“(2) there is a significant shortage of culturally competent residential treatment services for Urban Indian youth.

“SEC. 516. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

“(a) Grants Authorized.—The Secretary may make grants to those Urban Indian Organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among Urban Indians.

“(b) Goals.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

“(c) Establishment of Criteria.—The Secretary shall establish criteria for the grants made under subsection (a) relating to—

“(1) the size and location of the Urban Indian population to be served;

“(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among the Urban Indian population to be served;
“(3) performance standards for the organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

“(4) the capability of the organization to adequately perform the activities required under the grant; and

“(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the Area Office of the Service in which the organization is located.

“(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an Urban Indian Organization under this Act for the prevention, treatment, and control of diabetes among Urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

“SEC. 517. COMMUNITY HEALTH REPRESENTATIVES.

“The Secretary, acting through the Service, may enter into contracts with, and make grants to, Urban Indian Organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to Urban Indians.
“SEC. 518. EFFECTIVE DATE.

“The amendments made by the Indian Health Care Improvement Act Amendments of 2006 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

“SEC. 519. ELIGIBILITY FOR SERVICES.

“Urban Indians shall be eligible and the ultimate beneficiaries for health care or referral services provided pursuant to this title.

“SEC. 520. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 to carry out this title.

“TITLE VI—ORGANIZATIONAL IMPROVEMENTS

“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

“(a) Establishment.—

“(1) In general.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian Tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public

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Health Service of the Department the Indian Health Service.

“(2) DIRECTOR OF INDIAN HEALTH SERVICE.—The 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 shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2006, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

“(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2006 shall serve as Director.

“(4) ADVOCACY AND CONSULTATION.—The position of Director is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

“(A) facilitate advocacy for the development of appropriate Indian health policy; and

“(B) promote consultation on matters relating to Indian health.
“(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

“(c) DUTIES.—The Director shall—

“(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, carried out by or under the direction of the individual serving as Director of the Service on that day;

“(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

“(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including 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.);
“(4) administer all scholarship and loan func-
tions carried out under title I;
“(5) report directly to the Secretary concerning
all policy- and budget-related matters affecting In-
dian health;
“(6) collaborate with the Assistant Secretary
for Health concerning appropriate matters of Indian
health that affect the agencies of the Public Health
Service;
“(7) advise each Assistant Secretary of the De-
partment concerning matters of Indian health with
respect to which that Assistant Secretary has au-
thority and responsibility;
“(8) advise the heads of other agencies and pro-
grams of the Department concerning matters of In-
dian health with respect to which those heads have
authority and responsibility;
“(9) coordinate the activities of the Department
concerning matters of Indian health; and
“(10) perform such other functions as the Secretary may designate.

“(d) Authority.—

“(1) IN GENERAL.—The Secretary, acting through the Director, shall have the authority—

“(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

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

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

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

“SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

“(a) Establishment.—
“(1) IN GENERAL.—The Secretary shall establish an automated management information system for the Service.

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

“(A) a financial management system;

“(B) a patient care information system for each area served by the 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) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—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) Access to Records.—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

“(d) Authority to Enhance Information Technology.—The Secretary, acting through the Service, 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.


“There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 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 collaboration among alcohol and substance abuse, social services, and mental health programs.

“(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services.

“(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.
“(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop, implement, and coordinate with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

“(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

“(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

“(b) PLANS.—

“(1) DEVELOPMENT.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans, and Urban Indian Organizations to develop local plans, and for all such groups to participate in developing areawide plans for Indian Behavioral Health Services. The plans shall include, to the extent feasible, the following components:

“(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and
dysfunctional and self-destructive behavior, in-
cluding suicide, child abuse, and family vio-

ence, 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 preven-
tion 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 Sec-
retary, acting through the Service, shall coordinate
with existing national clearinghouses and informa-
tion centers to include at the clearinghouses and
centers plans and reports on the outcomes of such
plans developed by Indian Tribes, Tribal Organiza-
tions, 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) diagnostic services.
“(2) CHILD CARE.—Behavioral health services
for Indians from birth through age 17, including—
“(A) preschool and school age fetal alcohol
disorder services, including assessment and be-
behavioral intervention;
“(B) mental health and substance abuse
services (emotional, organic, alcohol, drug, in-
halant, and tobacco);
“(C) identification and treatment of co-oc-
curring disorders and comorbidity;
“(D) prevention of alcohol, drug, inhalant,
and tobacco use;
“(E) early intervention, treatment, and
aftercare;
“(F) promotion of healthy approaches to
risk and safety issues; and
“(G) identification and treatment of ne-
glect and physical, mental, and sexual abuse.
“(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

“(A) early intervention, treatment, and aftercare;

“(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

“(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

“(D) promotion of healthy approaches for risk-related behavior;

“(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder; and

“(F) sex specific treatment for sexual assault and domestic violence.

“(4) FAMILY CARE.—Behavioral health services for families, including—

“(A) early intervention, treatment, and aftercare for affected families;

“(B) treatment for sexual assault and domestic violence; and
“(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.

“(5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

“(A) early intervention, treatment, and aftercare;

“(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

“(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

“(D) promotion of healthy approaches to managing conditions related to aging;

“(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and

“(F) identification and treatment of dementias regardless of cause.

“(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

“(1) ESTABLISHMENT.—The governing body of any Indian Tribe, Tribal Organization, or Urban Indian Organization may adopt a resolution for the establishment of a community behavioral health plan
providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

“(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or Urban Indian Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe, Tribal Organization, or Urban Indian Organization in the development and implementation of such plan.

“(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

“(e) COORDINATION FOR AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organiza-
tions, 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 enactment of the Indian Health Care Improvement Act Amendments of 2006, 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 enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:
“(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

“(2) The existing Federal, tribal, State, local, and private services, resources, and programs available to provide behavioral health services for Indians.

“(3) The unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1).

“(4)(A) The right of Indians, as citizens of the United States and of the States in which they reside, to have access to behavioral health services to which all citizens have access.

“(B) The right of Indians to participate in, and receive the benefit of, such services.

“(C) The actions necessary to protect the exercise of such right.

“(5) The responsibilities of the Bureau of Indian Affairs and the Service, including mental illness identification, prevention, education, referral, and treatment services (including services through multi-disciplinary resource teams), at the central, area, and agency and Service Unit, Service Area, and
headquarters levels to address the problems identified in paragraph (1).

“(6) A strategy for the comprehensive coordination of the behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

“(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.)) with behavioral health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually diagnosed individuals requiring behavioral health and substance abuse treatment; and

“(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.
“(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service Unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

“(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian Tribes and Tribal Organizations.

“(b) SPECIFIC PROVISIONS REQUIRED.—The memorandum 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 alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

“(c) 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, which shall include—

“(A) prevention, through educational intervention, in Indian communities;
“(B) acute detoxification, psychiatric hospitalization, 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;

“(E) specialized residential treatment programs for high-risk populations, including pregnant and postpartum women and their children; and

“(F) diagnostic services.

“(2) TARGET POPULATIONS.—The target population of such programs shall be members of Indian Tribes. Efforts to train and educate key members of the Indian community shall also target employees of health, education, judicial, law enforcement, legal, and social service programs.

“(b) CONTRACT 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 as­
sistance 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 Serv­
vice, Indian Tribes, and Tribal Organizations, shall provide
high-standard paraprofessional training in mental health
care necessary to provide quality care to the Indian com-
munities 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 TECHNI-
CIANS.—The Secretary, acting through the Service, Indian
Tribes, and Tribal Organizations, shall supervise and
evaluate the mental health technicians in the training pro-
gram.

“(d) TRADITIONAL HEALTH CARE PRACTICES.—The
Secretary, acting through the Service, shall ensure that
the program established pursuant to this subsection in-
volves 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.

“(a) IN GENERAL.—Subject to the provisions of sec-
tion 221, and except as provided in subsection (b), any
individual 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 is required to be licensed as a psychologist,
social worker, or marriage and family therapist, respectively.

“(b) TRAINEES.—An individual may be employed as a trainee in psychology, social work, or marriage and family therapy to provide mental health care services described in subsection (a) if such individual—

“(1) works under the direct supervision of a licensed psychologist, social worker, or marriage and family therapist, respectively;

“(2) is enrolled in or has completed at least 2 years of course work at a post-secondary, accredited education program for psychology, social work, marriage and family therapy, or counseling; and

“(3) meets such other training, supervision, and quality review requirements as the Secretary may establish.

“SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

“(a) GRANTS.—The Secretary, consistent with section 701, may make grants to Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cultural, historical, social, and child care needs of Indian women, regardless of age.
“(b) USE OF GRANT FUNDS.—A grant made pursuant to this section may be used to—

“(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

“(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

“(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

“(c) CRITERIA.—The Secretary, in consultation with Indian Tribes and Tribal Organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

“(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the 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

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detoxification and treatment for Indian youths, including
behavioral health services. The program shall include re-
gional 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 (25
U.S.C. 450 et seq.). 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 con-
sidered 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(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).

“(B) Provision of Services to Eligible Youths.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youths residing in Alaska.

“(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 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 consultation with Indian Tribes and Tribal Organizations, shall—

“(A) identify and use, where appropriate, federally-owned structures suitable for local residential or regional behavioral health treatment for Indian youths; and

“(B) establish guidelines for determining the suitability of any such federally-owned structure to be used for local residential 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-
Indian Tribe or Tribal Organization operating the program.

“(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 members 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 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.

“(h) INDIAN YOUTH MENTAL HEALTH.—The Secretary, acting through the Service, shall collect data for the report under section 801 with respect to—

“(1) the number of Indian youth who are being provided mental health services through the Service and Tribal Health Programs;
“(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and Tribal Health Programs;

“(3) the number of youth referred to the Service or Tribal Health Programs for mental health services;

“(4) the number of Indian youth provided residential treatment for mental health and behavioral problems through the Service and Tribal Health Programs, reported separately for on- and off-reservation facilities; and

“(5) the costs of the services described in paragraph (4).

“SEC. 708. INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

“(a) PURPOSE.—The purpose of this section is to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention and treatment of Indian youth, including through—

“(1) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;
“(2) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

“(3) training and related support for community leaders, family members and health and education workers who work with Indian youth;

“(4) the development of culturally-relevant educational materials on suicide; and

“(5) data collection and reporting.

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

“(1) DEMONSTRATION PROJECT.—The term ‘demonstration project’ means the Indian youth telemental health demonstration project authorized under subsection (c).

“(2) TELEMENTAL HEALTH.—The term ‘telemental health’ means the use of electronic information and telecommunications technologies to support long distance mental health care, patient and professional-related education, public health, and health administration.

“(e) AUTHORIZATION.—

“(1) IN GENERAL.—The Secretary is authorized to award grants under the demonstration project for
the provision of telemental health services to Indian
youth who—

“(A) have expressed suicidal ideas;

“(B) have attempted suicide; or

“(C) have mental health conditions that in-
crease or could increase the risk of suicide.

“(2) Eligibility for grants.—Such grants
shall be awarded to Indian Tribes, Tribal Organiza-
tions, and Urban Indian Organizations that operate
1 or more facilities—

“(A) located in Alaska and part of the
Alaska Federal Health Care Access Network;

“(B) reporting active clinical telehealth ca-
pabilities; or

“(C) offering school-based telemental
health services relating to psychiatry to Indian
youth.

“(3) Grant period.—The Secretary shall
award grants under this section for a period of up
to 4 years.

“(4) Awarding of grants.—Not more than 5
grants shall be provided under paragraph (1), with
priority consideration given to Indian Tribes, Tribal
Organizations, and Urban Indian Organizations
that—
“(A) serve a particular community or geographic area where there is a demonstrated need to address Indian youth suicide;

“(B) enter into collaborative partnerships with Indian Health Service or other Tribal Health Programs or facilities to provide services under this demonstration project;

“(C) serve an isolated community or geographic area which has limited or no access to behavioral health services; or

“(D) operate a detention facility at which youth are detained.

“(d) USE OF FUNDS.—

“(1) IN GENERAL.—An Indian Tribe, Tribal Organization, or Urban Indian Organization shall use a grant received under subsection (c) for the following purposes:

“(A) To provide telemental health services to Indian youth, including the provision of—

“(i) psychotherapy;

“(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and
“(iii) alcohol and substance abuse treatment.

“(B) To provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to Service, tribal, or urban clinicians and health services providers working with youth being served under this demonstration project.

“(C) To assist, educate and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals and with State and local health services providers.

“(D) To develop and distribute culturally appropriate community educational materials on—

“(i) suicide prevention;

“(ii) suicide education;
“(iii) suicide screening;
“(iv) suicide intervention; and
“(v) ways to mobilize communities with respect to the identification of risk factors for suicide.
“(E) For data collection and reporting related to Indian youth suicide prevention efforts.
“(2) Traditional health care practices.—In carrying out the purposes described in paragraph (1), an Indian Tribe, Tribal Organization, or Urban Indian Organization may use and promote the traditional health care practices of the Indian Tribes of the youth to be served.
“(e) Applications.—To be eligible to receive a grant under subsection (c), an Indian Tribe, Tribal Organization, or Urban Indian Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—
“(1) a description of the project that the Indian Tribe, Tribal Organization, or Urban Indian Organization will carry out using the funds provided under the grant;
“(2) a description of the manner in which the project funded under the grant would—
“(A) meet the telemental health care needs of the Indian youth population to be served by the project; or

“(B) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

“(3) evidence of support for the project from the local community to be served by the project;

“(4) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

“(5) a plan to involve the tribal community of the youth who are provided services by the project in planning and evaluating the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

“(6) a plan for sustaining the project after Federal assistance for the demonstration project has terminated.

“(f) COLLABORATION; REPORTING TO NATIONAL CLEARINGHOUSE.—
“(1) **COLLABORATION.**—The Secretary, acting through the Service, shall encourage Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving grants under this section to collaborate to enable comparisons about best practices across projects.

“(2) **REPORTING TO NATIONAL CLEARING-HOUSE.**—The Secretary, acting through the Service, shall also encourage Indian Tribes, Tribal Organizations, and Urban Indian Organizations receiving grants under this section to submit relevant, declassified project information to the national clearing-house authorized under section 701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

“(g) **ANNUAL REPORT.**—Each grant recipient shall submit to the Secretary an annual report that—

“(1) describes the number of telemental health services provided; and

“(2) includes any other information that the Secretary may require.

“(h) **REPORT TO CONGRESS.**—Not later than 270 days after the termination of the demonstration project, the Secretary shall submit to the Committee on Indian Af-
fairs of the Senate and the Committee on Resources and
Committee on Energy and Commerce of the House of
Representatives a final report, based on the annual reports
provided by grant recipients under subsection (h), that—
“(1) describes the results of the projects funded
by grants awarded under this section, including any
data available which indicates the number of at­
tempted suicides; and
“(2) evaluates the impact of the telemental
health services funded by the grants in reducing the
number of completed suicides among Indian youth.
“(i) AUTHORIZATION OF APPROPRIATIONS.—There is
authorized to be appropriated to carry out this section
$1,500,000 for each of fiscal years 2007 through 2010.
“SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL
HEALTH FACILITIES DESIGN, CONSTRUC-
TION, AND STAFFING.
“Not later than 1 year after the date of enactment
of the Indian Health Care Improvement Act Amendments
of 2006, the Secretary, acting through the Service, Indian
Tribes, and Tribal Organizations, may provide, in each
area of the Service, not less than 1 inpatient mental health
care facility, or the equivalent, for Indians with behavioral
health problems. For the purposes of this subsection, Cali­
fornia 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. 710. TRAINING AND COMMUNITY EDUCATION.

“(a) Program.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian Tribes and Tribal Organizations 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 including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training 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. 711. 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) AWARDS; CRITERIA.—The Secretary may award a grant 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 project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

“SEC. 712. FETAL ALCOHOL DISORDER PROGRAMS.

“(a) PROGRAMS.—

“(1) ESTABLISHMENT.—The Secretary, consistent with section 701, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to 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.—

“(A) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

“(i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol disorders.
“(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian’s child.

“(iii) 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.

“(iv) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

“(v) To develop prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

“(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

“(vii) To develop and implement, in consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organiza-
tions, culturally sensitive assessment and
diagnostic tools including dysmorphology
clinics and multidisciplinary fetal alcohol
disorder clinics for use in Indian commu-
nities and Urban Centers.

“(B) ADDITIONAL USES.—In addition to
any purpose under subparagraph (A), funding
provided pursuant to this section may be used
for 1 or more of the following:

“(i) Early childhood intervention
projects from birth on to mitigate the ef-
teffects of fetal alcohol disorder among Indi-
ans.

“(ii) Community-based support serv-
ices for Indians and women pregnant with
Indian children.

“(iii) Community-based housing for
adult Indians with fetal alcohol disorder.

“(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 prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder in Indian communities; and

“(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

“(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 grants 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. 713. 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, pro-
grams 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 edu-
cation 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 values, and community involve-
ment.

“(4) To develop and implement culturally sen-
sitive assessment and diagnostic tools for use in In-
dian 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. 714. BEHAVIORAL HEALTH RESEARCH.

“The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, 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 multifactorial causes of Indian youth suicide, including—

“(A) protective and risk factors and scientific data that identifies those factors; and
“(B) the effects of loss of cultural identity and the development of scientific data on those effects;

“(2) 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

“(3) the development of models of prevention techniques.

The effect of the interrelationships and interdependencies referred to in paragraph (2) on children, and the development of prevention techniques under paragraph (3) applicable to children, shall be emphasized.

“SEC. 715. 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 aftercare.—The term ‘behavioral health aftercare’ includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as outpatient treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

“(4) Dual diagnosis.—The term ‘dual diagnosis’ means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are
sometimes referred to as mentally ill chemical abusers (MICAs).

“(5) Fetal alcohol disorders.—The term ‘fetal alcohol disorders’ means fetal alcohol syndrome, partial fetal alcohol syndrome and alcohol related neurodevelopmental disorder (ARND).

“(6) Fetal alcohol syndrome or FAS.—The term ‘fetal alcohol syndrome’ or ‘FAS’ means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

“(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

“(B) Craniofacial abnormalities with at least 2 of the following: microophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

“(C) Prenatal or postnatal growth delay.

“(7) Partial FAS.—The term ‘partial FAS’ means, with a history of maternal alcohol consumption during pregnancy, having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: microophthalmia, short palpebral
fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

“(8) REHABILITATION.—The term ‘rehabilitation’ means to restore the ability or capacity to engage in usual and customary life activities through education and therapy.

“(9) SUBSTANCE ABUSE.—The term ‘substance abuse’ includes inhalant abuse.

“SEC. 716. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 to carry out the provisions of this title.

“TITLE VIII—MISCELLANEOUS

“SEC. 801. REPORTS.

“For each fiscal year following the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary shall 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 par-
ity with the health services available to and the
health status of the general population.

“(2) A report on whether, and to what extent,
new national health care programs, benefits, initia-
tives, or financing systems have had an impact on
the purposes of this Act and any steps that the Sec-
retary may have taken to consult with Indian Tribes,
Tribal Organizations, and Urban Indian Organiza-
tions 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 rele-
vant 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 pop-
ulations; and

“(E) provided under contracts.

“(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 125(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(c).

“(9) A biennial report to Congress on infectious diseases as required by section 212.

“(10) A report on environmental and nuclear health hazards as required by section 215.

“(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2)(B) and 301(d).

“(12) Reports on safe water and sanitary waste disposal facilities as required by section 302(h).

“(13) An annual report on the expenditure of non-Service funds for renovation as required by sections 304(b)(2).
“(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities required by section 313(a).

“(15) A report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

“(16) A report on any arrangements for the sharing of medical facilities or services, 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).

“(20) A report on Indian youth mental health services as required by section 707(h).

“(21) A report on the reallocation of base resources if required by section 808.

“SEC. 802. REGULATIONS.

“(a) DEADLINES.—

“(1) PROCEDURES.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, 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 II (except section 202) and VII, the sections of title III for which negotiated rulemaking is specifically required, and sections 807 and 811. Unless otherwise required, the Secretary may promulgate regulations to carry out titles I, III, IV, and V, and section 202, using the procedures required by chapter V of title 5, United States Code (commonly known as the ‘Administrative Procedure Act’).

“(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006 and shall have no less than a 120-day comment period.

“(3) FINAL REGULATIONS.—The Secretary shall publish in the Federal Register final regulations to implement this Act by not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006.
“(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 and Tribal Organizations from each Service Area.

“(c) ADAPTATION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

“(d) LACK OF REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

“(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law in effect on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

“SEC. 803. PLAN OF IMPLEMENTATION.

“Not later than 9 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, the Secretary in consultation with Indian Tribes,
Tribal Organizations, and Urban Indian Organizations, shall submit to Congress a plan explaining the manner and schedule, by title and section, by which the Secretary will implement the provisions of this Act. This consultation may be conducted jointly with the annual budget consultation pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq).

"SEC. 804. AVAILABILITY OF FUNDS.

"The funds appropriated pursuant to this Act shall remain available until expended.

"SEC. 805. LIMITATIONS.

“(a) IN GENERAL.—Any limitation on the use of funds contained in an Act providing appropriations for the Department for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

“(b) NO LIABILITY.—Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this Act, the United States is not liable for the acts or omissions of any person in providing traditional health care practices under this Act that result in damage, injury, death, or any other outcome to any patient.
“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 Indian Tribe.

“(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

“(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 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 rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

“(b) 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 is 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 each Indian Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the
Indian Tribe or Tribal Organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

“(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 with-
out the Service Unit, available to meet the
health needs of such individuals.

“(2) ISDEAA PROGRAMS.—In the case of
health programs and facilities operated under a con­
tract or compact entered into under the Indian Self-
Determination and Education Assistance Act (25
U.S.C. 450 et seq.), the governing body of the In­
dian Tribe or Tribal Organization providing health
services under such contract or compact is author­
ized to determine whether health services should be
provided under such contract to individuals who are
not eligible for such health services under any other
subsection of this section or under any other provi­
sion of law. In making such determinations, the gov­
erning body of the Indian Tribe or Tribal Organiza­
tion shall take into account the considerations de­
scribed in paragraph (1)(B).

“(3) PAYMENT FOR SERVICES.—

“(A) IN GENERAL.—Persons receiving
health services provided by the Service under
this subsection shall be liable for payment of
such health services under a schedule of charges
prescribed by the Secretary which, in the judg­
ment of the Secretary, results in reimbursement
in an amount not less than the actual cost of
providing the health services. Notwithstanding
section 404 of this Act or any other provision
of law, amounts collected under this subsection,
including Medicare, Medicaid, or SCHIP reim-
bursements under titles XVIII, XIX, and XXI
of the Social Security Act, shall be credited to
the account of the program providing the serv-
ice and shall be used for the purposes listed in
section 401(d)(2) and amounts collected under
this subsection shall be available for expendi-
ture within such program.

“(B) INDIGENT PEOPLE.—Health services
may be provided by the Secretary through the
Service under this subsection to an indigent in-
dividual 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 succeeding the fiscal year in which the governing body of the Indian Tribe revokes its concurrence to the provision of such health services.

“(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services 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 individual 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 contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) 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, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

“(f) ELIGIBLE INDIAN.—For purposes of this section, the term ‘eligible Indian’ means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.
“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 program, project, or activity of a Service Unit may be implemented only after the Secretary has submitted to Congress, under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

(b) 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 appropriated 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 contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall not be considered an ‘employer’.
SEC. 813. 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. 814. ESTABLISHMENT OF NATIONAL BIPARTISAN COMMISSION ON INDIAN HEALTH CARE.

"(a) Establishment.—There is established the National Bipartisan Indian Health Care 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, In-
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. The study committee shall also evaluate utilization rates by Indians at Indian Health Programs and Urban Indian Organizations programs, existing or potential disincentives to any overutilization of health care services, existing or potential incentives to spend health care resources prudently, and the concepts of, and potential incentives to, achieving personal responsibility of Indians or a more direct role of Indians in their personal health care management plans or decisions.

“(B) To make legislative recommendations to the Commission regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financ-
ing such services, and the optimal manner in
which to provide such services.

“(C) To determine the effect of the enact-
ment of such recommendations on (i) the exist-
ing system of delivery of health services for In-
dians, 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 Com-
mission.

“(E) To report regularly to the full Com-
mision regarding the findings and rec-
ommendations developed by the study com-
mittee in the course of carrying out its duties
under this section.

“(2) To review and analyze the recommenda-
tions of the report of the study committee.
“(3) To make legislative recommendations to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

“(4) Not later than 18 months following the date of appointment of all members of the Commission, submit a written report to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

“(c) Members.—

“(1) Appointment.—The Commission shall be composed of 25 members, appointed as follows:

“(A) Ten members of Congress, including 3 from the House of Representatives and 2 from the Senate, appointed by their respective majority leaders, and 3 from the House of Representatives and 2 from the Senate, appointed by their respective minority leaders, and who
shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

“(B) Twelve persons chosen by the congressional members of the Commission, 1 from each Service Area as currently designated by the Director to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

“(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.
“(D) All those persons chosen by the congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

“(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the congressional members of the Commission.

“(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

“(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2006, 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 ent-
titled to receive compensation at the per diem equi-
valent of the rate provided for level IV of the Execu-
tive 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 mem-
ber may be allowed travel expenses, as authorized by
the Chairman of the Commission. For purpose of
pay (other than pay of members of the Commission)
and employment benefits, rights, and privileges, all
personnel of the Commission shall be treated as if
they were employees of the United States Senate.

“(e) MEETINGS.—The Commission shall meet at the
call of the Chair.

“(f) QUORUM.—A quorum of the Commission shall
consist of not less than 15 members, provided that no less
than 6 of the members of Congress who are Commission
members are present and no less than 9 of the members
who are Indians are present.

“(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—
“(1) **APPOINTMENT; PAY.**—The Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

“(2) **STAFF APPOINTMENT.**—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

“(3) **STAFF PAY.**—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

“(4) **TEMPORARY SERVICES.**—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

“(5) **FACILITIES.**—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals.
required for the proper functioning of the Commission.

“(h) Hearings.—(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count toward the number of regional hearings required by this subsection.

“(2) Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

“(3)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost esti-
mates 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 that 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.


“SEC. 815. APPROPRIATIONS; AVAILABILITY.

“Any new spending authority (described in subparagraph (A) or (B) of section 401(e)(2) of the Congressional
Which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

"SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

(a) In General.—There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2016 to carry out this title.

SEC. 102. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following:

"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. 103. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) In General.—The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:
TITLE VIII—NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION

SEC. 801. DEFINITIONS.

In this title:

(1) BOARD.—The term ‘Board’ means the Board of Directors of the Foundation.

(2) COMMITTEE.—The term ‘Committee’ means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802(f).

(3) FOUNDATION.—The term ‘Foundation’ means the Native American Health and Wellness Foundation established under section 802.

(4) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.

(5) SERVICE.—The term ‘Service’ means the Indian Health Service of the Department of Health and Human Services.

SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District
of Columbia and in accordance with this title, the
Native American Health and Wellness Foundation.

“(2) FUNDING DETERMINATIONS.—No funds, gift, property, or other item of value (including any interest accrued on such an item) acquired by the Foundation shall—

“(A) be taken into consideration for purposes of determining Federal appropriations relating to the provision of health care and services to Indians; or

“(B) otherwise limit, diminish, or affect the Federal responsibility for the provision of health care and services to Indians.

“(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

“(c) NATURE OF CORPORATION.—The Foundation—

“(1) shall be a charitable and nonprofit federally chartered corporation; and

“(2) shall not be an agency or instrumentality of the United States.

“(d) PLACE OF INCORPORATION AND DOMICILE.— The Foundation shall be incorporated and domiciled in the District of Columbia.

“(e) DUTIES.—The Foundation shall—
“(1) encourage, accept, and administer private
gifts of real and personal property, and any income
from or interest in such gifts, for the benefit of, or
in support of, the mission of the Service;
“(2) undertake and conduct such other activi-
ties as will further the health and wellness activities
and opportunities of Native Americans; and
“(3) participate with and assist Federal, State,
and tribal governments, agencies, entities, and indi-
viduals in undertaking and conducting activities that
will further the health and wellness activities and op-
portunities of Native Americans.
“(f) COMMITTEE FOR THE ESTABLISHMENT OF Na-
tive American Health and Wellness Foun-
dation.—
“(1) IN GENERAL.—The Secretary shall estab-
lish the Committee for the Establishment of Native
American Health and Wellness Foundation to assist
the Secretary in establishing the Foundation.
“(2) DUTIES.—Not later than 180 days after
the date of enactment of this section, the Committee
shall—
“(A) carry out such activities as are nec-
essary to incorporate the Foundation under the
laws of the District of Columbia, including acting as incorporators of the Foundation;

“(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

“(C) establish the constitution and initial bylaws of the Foundation;

“(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

“(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

“(g) BOARD OF DIRECTORS.—

“(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

“(2) POWERS.—The Board may exercise, or provide for the exercise of, the powers of the Foundation.

“(3) SELECTION.—

“(A) IN GENERAL.—Subject to subparagraph (B), the number of members of the Board, the manner of selection of the members (including the filling of vacancies), and the
terms of office of the members shall be as pro-
vided in the constitution and bylaws of the
Foundation.

“(B) REQUIREMENTS.—

“(i) NUMBER OF MEMBERS.—The
Board shall have at least 11 members, who
shall have staggered terms.

“(ii) INITIAL VOTING MEMBERS.—The
initial voting members of the Board—

“(I) shall be appointed by the
Committee not later than 180 days
after the date on which the Founda-
tion is established; and

“(II) shall have staggered terms.

“(iii) QUALIFICATION.—The members
of the Board shall be United States citi-
zens who are knowledgeable or experienced
in Native American health care and related
matters.

“(C) COMPENSATION.—A member of the
Board shall not receive compensation for service
as a member, but shall be reimbursed for actual
and necessary travel and subsistence expenses
incurred in the performance of the duties of the
Foundation.
“(h) Officers.—

“(1) In General.—The officers of the Foundation shall be—

“(A) a secretary, elected from among the members of the Board; and

“(B) any other officers provided for in the constitution and bylaws of the Foundation.

“(2) Chief Operating Officer.—The secretary of the Foundation may serve, at the direction of the Board, as the chief operating officer of the Foundation, or the Board may appoint a chief operating officer, who shall serve at the direction of the Board.

“(3) Election.—The manner of election, term of office, and duties of the officers of the Foundation shall be as provided in the constitution and bylaws of the Foundation.

“(i) Powers.—The Foundation—

“(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

“(2) may adopt and alter a corporate seal;

“(3) may enter into contracts;

“(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal...
property as necessary or convenient to carry out the purposes of the Foundation;

“(5) may sue and be sued; and

“(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

“(j) **Principal Office.**—

“(1) **In General.**—The principal office of the Foundation shall be in the District of Columbia.

“(2) **Activities; Offices.**—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

“(k) **Service of Process.**—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

“(l) **Liability of Officers, Employees, and Agents.**—

“(1) **In General.**—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

“(2) **Personal Liability.**—A member of the Board shall be personally liable only for gross neg-
ligence in the performance of the duties of the mem-
ber.

“(m) Restrictions.—

“(1) Limitation on spending.—Beginning
with the fiscal year following the first full fiscal year
during which the Foundation is in operation, the ad-
ministrative costs of the Foundation shall not exceed
the percentage described in paragraph (2) of the
sum of—

“(A) the amounts transferred to the Foun-
dation under subsection (o) during the pre-
ceding fiscal year; and

“(B) donations received from private
sources during the preceding fiscal year.

“(2) Percentages.—The percentages referred
to in paragraph (1) are—

“(A) for the first fiscal year described in
that paragraph, 20 percent;

“(B) for the following fiscal year, 15 per-
cent; and

“(C) for each fiscal year thereafter, 10
percent.

“(3) Appointment and hiring.—The ap-
pointment of officers and employees of the Founda-
tion shall be subject to the availability of funds.
“(4) STATUS.—A member of the Board or officer, employee, or agent of the Foundation shall not by reason of association with the Foundation be considered to be an officer, employee, or agent of the United States.

“(n) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

“(o) FUNDING.—

“(1) Authorization of Appropriations.—There is authorized to be appropriated to carry out subsection (e)(1) $500,000 for each fiscal year, as adjusted to reflect changes in the Consumer Price Index for all-urban consumers published by the Department of Labor.

“(2) Transfer of Donated Funds.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.
SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.

(a) Provision of Support by Secretary.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

(1) may provide personnel, facilities, and other administrative support services to the Foundation;

(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board; and

(3) shall require and accept reimbursements from the Foundation for—

(A) services provided under paragraph (1); and

(B) funds provided under paragraph (2).

(b) Reimbursement.—Reimbursements accepted under subsection (a)(3)—

(1) shall be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

(c) Continuation of Certain Services.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination
of the 5-year period specified in subsection (a) if the facili-
ties and services—

“(1) are available; and

“(2) are provided on reimbursable cost basis.”.

(b) TECHNICAL AMENDMENTS.—The Indian Self-Deter-
mination and Education Assistance Act is amended—

(1) by redesignating title V (25 U.S.C. 458bbb
et seq.) as title VII;

(2) by redesignating sections 501, 502, and 503
(25 U.S.C. 458bbb, 458bbb–1, 458bbb–2) as sec-
tions 701, 702, and 703, respectively; and

(3) in subsection (a)(2) of section 702 and
paragraph (2) of section 703 (as redesignated by
paragraph (2)), by striking “section 501” and in-
serting “section 701”.

TITLE II—IMPROVEMENT OF IN-
DIAN HEALTH CARE PRO-
Vided UNDER THE SOCIAL
SECURITY ACT

SEC. 201. EXPANSION OF PAYMENTS UNDER MEDICARE,

MEDICAID, AND SCHIP FOR ALL COVERED
SERVICES FURNISHED BY INDIAN HEALTH
PROGRAMS.

(a) MEDICAID.—
(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:

“SEC. 1911. INDIAN HEALTH PROGRAMS.; and

(B) by amending subsection (a) to read as follows:

“(a) Eligibility for Payment for Medical Assistance.—The Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization shall be eligible for payment for medical assistance provided under a State plan or under waiver authority with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title and under such plan or waiver authority.”.

(2) Compliance with Conditions and Requirements.—Subsection (b) of such section is amended to read as follows:

“(b) Compliance With Conditions and Requirements.—A facility of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Or-
ganization which is eligible for payment under subsection (a) with respect to the furnishing of items and services, but which does not meet all of the conditions and requirements of this title and under a State plan or waiver authority which are applicable generally to such facility, shall make such improvements as are necessary to achieve or maintain compliance with such conditions and requirements in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements, and shall be deemed to meet such conditions and requirements (and to be eligible for payment under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.”.

(3) Revision of authority to enter into agreements.—Subsection (c) of such section is amended to read as follows:

“(c) Authority To Enter Into Agreements.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided by the Indian Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization (as so defined), directly, through referral, or under contracts or other arrangements between the Indian
Health Service, an Indian Tribe, Tribal Organization, or an Urban Indian Organization and another health care provider to Indians who are eligible for medical assistance under the State plan or under waiver authority.’’.

(4) Cross-references to special fund for improvement of IHS facilities; direct billing option; definitions.—Such section is further amended by striking subsection (d) and adding at the end the following new subsections:

“(d) Special Fund for Improvement of IHS Facilities.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

“(e) Direct Billing.—For provisions relating to the authority of a Tribal Health Program or an Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such Program or Organization for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.
“(f) DEFINITIONS.—In this section, the terms ‘Indian Health Program’, ‘Indian Tribe’, ‘Tribal Health Program’, ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.”.

(b) MEDICARE.—

(1) EXPANSION TO ALL COVERED SERVICES.—

Section 1880 of such Act (42 U.S.C. 1395qq) is amended—

(A) by amending the heading to read as follows:

"SEC. 1880. INDIAN HEALTH PROGRAMS."; and

(B) by amending subsection (a) to read as follows:

“(a) ELIGIBILITY FOR PAYMENTS.—Subject to subsection (e), the Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization shall be eligible for payments under this title with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization if the furnishing of such services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under this title.”.
(2) **Compliance with conditions and requirements.**—Subsection (b) of such section is amended to read as follows:

“(b) **Compliance With Conditions and Requirements.**—Subject to subsection (e), a facility of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization which is eligible for payment under subsection (a) with respect to the furnishing of items and services, but which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, shall make such improvements as are necessary to achieve or maintain compliance with such conditions and requirements in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements, and shall be deemed to meet such conditions and requirements (and to be eligible for payment under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.”.

(3) **Cross-references to special fund for improvement of IHS facilities; direct billing option; definitions.**—
(A) IN GENERAL.—Such section is further amended by striking subsections (c) and (d) and inserting the following new subsections:

“(c) SPECIAL FUND FOR IMPROVEMENT OF IHS FACILITIES.—For provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is eligible for payment under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

“(d) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program or an Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such Program or Organization for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.”.

(B) CONFORMING AMENDMENT.—Paragraph (3) of section 1880(e) of such Act (42 U.S.C. 1395qq(e)) is amended by inserting “and section 401(c)(1) of the Indian Health Care Improvement Act” after “Subsection (c)”.

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(4) DEFINITIONS.—Such section is further amended by amending subsection (f) to read as follows:

“(f) DEFINITIONS.—In this section, the terms ‘Indian Health Program’, ‘Indian Tribe’, ‘Service Unit’, ‘Tribal Health Program’, ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.”.

(c) APPLICATION TO SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C), the following new subparagraph:

“(D) Section 1911 (relating to Indian Health Programs, other than subsection (d) of such section).”.
SEC. 202. INCREASED OUTREACH TO INDIANS UNDER MEDICAID AND SCHIP AND IMPROVED COOPERATION IN THE PROVISION OF ITEMS AND SERVICES TO INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9) is amended to read as follows:

“SEC. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XVIII, XIX, AND XXI.

“(a) AGREEMENTS WITH STATES FOR MEDICAID AND SCHIP OUTREACH ON OR NEAR RESERVATIONS TO INCREASE THE ENROLLMENT OF INDIANS IN THOSE PROGRAMS.—

“(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children’s health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps 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 the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits,
enrollment, and translation services when such services are appropriate.

“(2) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such titles.

“(b) REQUIREMENT TO FACILITATE 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 Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI.

“(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms ‘Indian’, ‘Indian Tribe’, ‘Indian Health Program’, ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.”.
SEC. 203. ADDITIONAL PROVISIONS TO INCREASE OUTREACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID.

(a) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(e)(2) of the Social Security Act (42 U.S.C. 1397ee(e)(2)) is amended by adding at the end the following new subparagraph:

“(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF INDIAN CHILDREN UNDER THIS TITLE AND TITLE XIX.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(1)(D) shall not apply in the case of expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1139(a).”.

(b) ASSURANCE OF PAYMENTS TO INDIAN HEALTH CARE PROVIDERS FOR CHILD HEALTH ASSISTANCE.—
Section 2102(b)(3)(D) of such Act (42 U.S.C. 1397bb(b)(3)(D)) is amended by striking “(as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c))” and inserting “, including how the State will ensure that payments are made to Indian Health Programs and Urban Indian Organizations operating in the State for the provision of such assistance”.

(c) Inclusion of Other Indian Financed Health Care Programs in Exemption From Prohibition on Certain Payments.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by striking “insurance program, other than an insurance program operated or financed by the Indian Health Service” and inserting “program, other than a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization”.

(d) Satisfaction of Medicaid Documentation Requirements.—

(1) In general.—Section 1903(x)(3)(B) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)) is amended—

(A) by redesignating clause (v) as clause (vi); and
(B) by inserting after clause (iv), the fol-
lowing new clause:

“(v)(I) Except as provided in subclause (II), a
document issued by a federally-recognized Indian
tribe evidencing membership or enrollment in, or af-
filiation with, such tribe.

“(II) With respect to those federally-recognized
Indian tribes located within States having an inter-
ational border whose membership includes individ-
uals who are not citizens of the United States, the
Secretary shall, after consulting with such tribes,
issue regulations authorizing the presentation of
such other forms of documentation (including tribal
documentation, if appropriate) that the Secretary
determines to be satisfactory documentary evidence
of citizenship or nationality for purposes of satis-
fying the requirement of this subsection.”.

(2) TRANSITION RULE.—During the period that
begins on July 1, 2006, and ends on the effective
date of final regulations issued under subclause (II)
of section 1903(x)(3)(B)(v) of the Social Security
Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by
paragraph (1)), an individual who is a member of a
federally-recognized Indian tribe described in sub-
clause (II) of that section who presents a document
described in subclause (I) of such section that is
issued by such Indian tribe, shall be deemed to have
presented satisfactory evidence of citizenship or na-
tionality for purposes of satisfying the requirement
of subsection (x) of section 1903 of such Act.

(e) DEFINITIONS.—Section 2110(e) of such Act (42
U.S.C. 1397jj(e)) is amended by adding at the end the
following new paragraph:

“(9) INDIAN; INDIAN HEALTH PROGRAM; IN-
DIAN TRIBE; ETC.—The terms ‘Indian’, ‘Indian
Health Program’, ‘Indian Tribe’, ‘Tribal Organiza-
tion’, and ‘Urban Indian Organization’ have the
meanings given those terms in section 4 of the In-
dian Health Care Improvement Act.”.

SEC. 204. PREMIUMS AND COST SHARING PROTECTIONS
UNDER MEDICAID, ELIGIBILITY DETERMINA-
TIONS UNDER MEDICAID AND SCHIP, AND
PROTECTION OF CERTAIN INDIAN PROPERTY
FROM MEDICAID ESTATE RECOVERY.

(a) PREMIUMS AND COST SHARING PROTECTION
UNDER MEDICAID.—

(1) IN GENERAL.—Section 1916 of the Social
Security Act (42 U.S.C. 1396o) is amended—
(A) in subsection (a), in the matter preceding paragraph (1), by striking “and (i)” and inserting “, (i), and (j)”; and

(B) by adding at the end the following new subsection:

“(j) No Premiums or Cost Sharing for Indians Furnished Items or Services Directly by Indian Health Programs or Through Referral Under the Contract Health Service.—

“(1) No cost sharing for items or services furnished to Indians through Indian health programs.—

“(A) In general.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under the contract health service for which payment may be made under this title.

“(B) No reduction in amount of payment to Indian health providers.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization,
or Urban Indian Organization, or a health care
provider through referral under the contract
health service for the furnishing of an item or
service to an Indian who is eligible for assist-
ance under such title, may not be reduced by
the amount of any enrollment fee, premium, or
similar charge, or any deduction, copayment,
cost sharing, or similar charge that would be
due from the Indian but for the operation of
subparagraph (A).

“(2) RULE OF CONSTRUCTION.—Nothing in
this subsection shall be construed as restricting the
application of any other limitations on the imposi-
tion of premiums or cost sharing that may apply to
an individual receiving medical assistance under this
title who is an Indian.

“(3) DEFINITIONS.—In this subsection, the
terms ‘contract health service’, ‘Indian’, ‘Indian
Tribe’, ‘Tribal Organization’, and ‘Urban Indian Or-
ganization’ have the meanings given those terms in
section 4 of the Indian Health Care Improvement
Act.”.

(2) CONFORMING AMENDMENT.—Section
1916A (a)(1) of such Act (42 U.S.C. 1396o–1(a)(1))
is amended by striking “section 1916(g)” and inserting “subsections (g), (i), or (j) of section 1916”.

(b) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID AND SCHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new paragraph:

“(13) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property for purposes of determining the eligibility of an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act) for medical assistance under this title:

“(A) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe’s reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as
designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

“(B) For any federally recognized Tribe not described in subparagraph (A), property located within the most recent boundaries of a prior Federal reservation.

“(C) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

“(D) Ownership interests in or usage rights to items not covered by subparagraphs (A) through (C) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.”.

(2) Application to SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—
(A) by redesignating subparagraphs (B) through (E), as subparagraphs (C) through (F), respectively; and

(B) by inserting after subparagraph (A), the following new subparagraph:

“(B) Section 1902(e)(13) (relating to disregard of certain property for purposes of making eligibility determinations).”.

(e) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—

(1) by inserting “(A)” after “(3)”; and

(2) by adding at the end the following new subparagraph:

“(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in
this subparagraph shall be construed as pre­
venting the Secretary from providing additional
estate recovery exemptions under this title for
Indians.”.

SEC. 205. Nondiscrimination in Qualifications for
Payment for Services Under Federal
Health Care Programs.

Section 1139 of the Social Security Act (42 U.S.C.
1320b–9), as amended by section 202, is amended by re­
designating subsection (c) as subsection (d), and inserting
after subsection (b) the following new subsection:

“(c) Nondiscrimination in Qualifications for
Payment for Services Under Federal Health
Care Programs.—

“(1) Requirement to satisfy generally
applicable participation requirements.—

“(A) In general.—A Federal health care
program must accept an entity that is operated
by the Indian Health Service, an Indian Tribe,
Tribal Organization, or Urban Indian Organiza­
tion as a provider eligible to receive payment
under the program for health care services fur­
nished to an Indian on the same basis as any
other provider qualified to participate as a pro­
vider of health care services under the program
if the entity meets generally applicable State or
other requirements for participation as a pro-
vider of health care services under the program.

“(B) SATISFACTION OF STATE OR LOCAL
LICENSURE OR RECOGNITION REQUIRE-
MENTS.—Any requirement for participation as
a provider of health care services under a Fed-
eral health care program that an entity be li-
censed or recognized under the State or local
law where the entity is located to furnish health
care services shall be deemed to have been met
in the case of an entity operated by the Indian
Health Service, an Indian Tribe, Tribal Organi-
zation, or Urban Indian Organization if the en-
tity meets all the applicable standards for such
licensure or recognition, regardless of whether
the entity obtains a license or other documenta-
tion under such State or local law. In accord-
ance with section 221 of the Indian Health
Care Improvement Act, the absence of the licen-
sure of a health care professional employed by
such an entity under the State or local law
where the entity is located shall not be taken
into account for purposes of determining wheth-
or the entity meets such standards, if the professional is licensed in another State.

“(2) Prohibition on Federal payments to entities or individuals excluded from participation in Federal health care programs or whose state licenses are under suspension or have been revoked.—

“(A) Excluded entities.—No entity operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment under any such program for health care services furnished to an Indian.

“(B) Excluded individuals.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension or has been revoked shall be eligible to receive payment under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to
1 receive payment for health care services, to an
2 Indian.
3 “(C) Federal health care program
4 defined.—In this subsection, the term, ‘Fed-
5 eral health care program’ has the meaning
6 given that term in section 1128B(f), except
7 that, for purposes of this subsection, such term
8 shall include the health insurance program
9 under chapter 89 of title 5, United States
10 Code.”.
11
12 SEC. 206. CONSULTATION ON MEDICAID, SCHIP, AND
13 OTHER HEALTH CARE PROGRAMS FUNDED
14 UNDER THE SOCIAL SECURITY ACT INVOLV-
15 ING INDIAN HEALTH PROGRAMS AND URBAN
16 INDIAN ORGANIZATIONS.
17 (a) In general.—Section 1139 of the Social Secu-
18 rity Act (42 U.S.C. 1320b–9), as amended by sections 202
19 and 205, is amended by redesignating subsection (d) as
20 subsection (e), and inserting after subsection (e) the fol-
21 lowing new subsection:
22 “(d) Consultation with Tribal Technical Ad-
23 visory Group (TTAG).—The Secretary shall maintain
24 within the Centers for Medicaid & Medicare Services
25 (CMS) a Tribal Technical Advisory Group, established in
26 accordance with requirements of the charter dated Sep-
tember 30, 2003, and in such group shall include a rep-
resentative of the Urban Indian Organizations and the
Service. The representative of the Urban Indian Organiza-
tion shall be deemed to be an elected officer of a tribal
government for purposes of applying section 204(b) of the
Unfunded Mandates Reform Act of 1995 (2 U.S.C.
1534(b)).”.

(b) SOLICITATION OF ADVICE UNDER MEDICAID AND
SCHIP.—

(1) MEDICAID STATE PLAN AMENDMENT.—Sec-
tion 1902(a) of the Social Security Act (42 U.S.C.
1396a(a)) is amended—

(A) in paragraph (69), by striking “and”
at the end;

(B) in paragraph (70)(B)(iv), by striking
the period at the end and inserting “; and”;
and

(C) by inserting after paragraph
(70)(B)(iv), the following new paragraph:

“(71) in the case of any State in which the In-
dian Health Service operates or funds health care
programs, or in which 1 or more Indian Health Pro-
grams or Urban Indian Organizations (as such
terms are defined in section 4 of the Indian Health
Care Improvement Act) provide health care in the
State for which medical assistance is available under such title, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

“(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

“(B) 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 State plan under this title.”.

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by section 204(b)(2), is amended—
(A) by redesignating subparagraphs (B) through (F) as subparagraphs (C) through (G), respectively; and

(B) by inserting after subparagraph (A), the following new subparagraph:

“(B) Section 1902(a)(71) (relating to the option of certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).”.

c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

SEC. 207. EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS AND SAFE HARBOR TRANSACTIONS UNDER THE SOCIAL SECURITY ACT.

(a) Exclusion Waiver Authority.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

“(k) ADDITIONAL EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS.—In addition to the authority granted the Secretary under sub-
sections (c)(3)(B) and (d)(3)(B) to waive an exclusion under subsection (a)(1), (a)(3), (a)(4), or (b), the Secretary may, in the case of an Indian Health Program, waive such an exclusion upon the request of the administrator of an affected Indian Health Program (as defined in section 4 of the Indian Health Care Improvement Act) who determines that the exclusion would impose a hardship on individuals entitled to benefits under or enrolled in a Federal health care program.”.

(b) CERTAIN TRANSACTIONS INVOLVING INDIAN HEALTH CARE PROGRAMS DEEMED TO BE IN SAFE HARBORS.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

“(4) Subject to such conditions as the Secretary may promulgate from time to time as necessary to prevent fraud and abuse, for purposes of paragraphs (1) and (2) and section 1128A(a), the following transfers shall not be treated as remuneration:

“(A) TRANSFERS BETWEEN INDIAN HEALTH PROGRAMS, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—Transfers of anything of value between or among an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, that are made for the
purpose of providing necessary health care items and
services to any patient served by such Program, Tribe, or Organization and that consist of—

“(i) services in connection with the collection, transport, analysis, or interpretation of diagnostic specimens or test data;

“(ii) inventory or supplies;

“(iii) staff; or

“(iv) a waiver of all or part of premiums or cost sharing.

“(B) TRANSFERS BETWEEN INDIAN HEALTH PROGRAMS, INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS AND PATIENTS.—Transfers of anything of value between an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization and any patient served or eligible for service from an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, including any patient served or eligible for service pursuant to section 807 of the Indian Health Care Improvement Act, but only if such transfers—

“(i) consist of expenditures related to providing transportation for the patient for the provision of necessary health care items or serv-
ices, provided that the provision of such trans-
portation is not advertised, nor an incentive of
which the value is disproportionately large in
relationship to the value of the health care item
or service (with respect to the value of the item
or service itself or, for preventative items or
services, the future health care costs reasonably
expected to be avoided);

“(ii) consist of expenditures related to pro-
viding housing to the patient (including a preg-
nant patient) and immediate family members or
an escort necessary to assuring the timely pro-
vision of health care items and services to the
patient, provided that the provision of such
housing is not advertised nor an incentive of
which the value is disproportionately large in
relationship to the value of the health care item
or service (with respect to the value of the item
or service itself or, for preventative items or
services, the future health care costs reasonably
expected to be avoided); or

“(iii) are for the purpose of paying pre-
miums or cost sharing on behalf of such a pa-
tient, provided that the making of such pay-
ment is not subject to conditions other than
conditions agreed to under a contract for the
delivery of contract health services.

“(C) CONTRACT HEALTH SERVICES.—A trans-
fer of anything of value negotiated as part of a con-
tract entered into between an Indian Health Pro-
gram, Indian Tribe, Tribal Organization, Urban In-
dian Organization, or the Indian Health Service and
a contract care provider for the delivery of contract
health services authorized by the Indian Health
Service, provided that—

“(i) such a transfer is not tied to volume
or value of referrals or other business generated
by the parties; and

“(ii) any such transfer is limited to the fair
market value of the health care items or serv-
ices provided or, in the case of a transfer of
items or services related to preventative care,
the value of the future health care costs reason-
ably expected to be avoided.

“(D) OTHER TRANSFERS.—Any other transfer
of anything of value involving an Indian Health Pro-
gram, Indian Tribe, Tribal Organization, or Urban
Indian Organization, or a patient served or eligible
for service from an Indian Health Program, Indian
Tribe, Tribal Organization, or Urban Indian Organi-
zation, that the Secretary, in consultation with the
Attorney General, determines is appropriate, taking
into account the special circumstances of such In-
dian Health Programs, Indian Tribes, Tribal Orga-
nizations, and Urban Indian Organizations, and of
patients served by such Programs, Tribes, and Orga-
nizations.’’.

SEC. 208. RULES APPLICABLE UNDER MEDICAID AND
SCHIP TO MANAGED CARE ENTITIES WITH
RESPECT TO INDIAN ENROLLEES AND IN-
DIAN HEALTH CARE PROVIDERS AND INDIAN
MANAGED CARE ENTITIES.

(a) In General.—Section 1932 of the Social Secu-

rity Act (42 U.S.C. 1396u–2) is amended by adding at
the end the following new subsection:

“(h) Special Rules With Respect to Indian En-
rollees, Indian Health Care Providers, and In-
dian Managed Care Entities.—

“(1) Enrollee option to select an Indian
health care provider as primary care pro-
vider.—In the case of a non-Indian Medicaid man-
aged care entity that—

“(A) has an Indian enrolled with the enti-
ty; and
“(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity, insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian’s primary care provider under the entity.

“(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity that has a significant percentage of Indian enrollees (as determined by the Secretary), as a condition of receiving payment under such contract to satisfy the following requirements:

“(A) DEMONSTRATION OF PARTICIPATING INDIAN HEALTH CARE PROVIDERS OR APPLICA-
TION OF ALTERNATIVE PAYMENT ARRANGE-
MENTS.—Subject to subparagraph (E), to—

“(i) demonstrate that the number of
Indian health care providers that are par-
ticipating providers with respect to such
entity are sufficient to ensure timely access
to covered Medicaid managed care services
for those enrollees who are eligible to re-
ceive services from such providers; or

“(ii) agree to pay Indian health care
providers who are not participating pro-
viders with the entity for covered Medicaid
managed care services provided to those
enrollees who are eligible to receive services
from such providers at a rate equal to the
rate negotiated between such entity and
the provider involved or, if such a rate has
not been negotiated, at a rate that is not
less than the level and amount of payment
which the entity would make for the serv-
ices if the services were furnished by a par-
ticipating provider which is not an Indian
health care provider.

“(B) PROMPT PAYMENT.—To agree to
make prompt payment (in accordance with
rules applicable to managed care entities) to In-
dian health care providers that are participating
providers with respect to such entity or, in the
case of an entity to which subparagraph (A)(ii)
or (E) applies, that the entity is required to pay
in accordance with that subparagraph.

“(C) SATISFACTION OF CLAIM REQUIRE-
MENT.—To deem any requirement for the sub-
mission of a claim or other documentation for
services covered under subparagraph (A) by the
enrollee to be satisfied through the submission
of a claim or other documentation by an Indian
health care provider that is consistent with sec-
section 403(h) of the Indian Health Care Improve-
ment Act.

“(D) COMPLIANCE WITH GENERALLY AP-
PLICABLE REQUIREMENTS.—

“(i) IN GENERAL.—Subject to clause
(ii), as a condition of payment under sub-
paragraph (A), an Indian health care pro-
vider shall comply with the generally appli-
cable requirements of this title, the State
plan, and such entity with respect to cov-
ered Medicaid managed care services pro-
vided by the Indian health care provider to
the same extent that non-Indian providers participating with the entity must comply with such requirements.

(ii) LIMITATIONS ON COMPLIANCE WITH MANAGED CARE ENTITY GENERALLY APPLICABLE REQUIREMENTS.—An Indian health care provider—

(I) shall not be required to comply with a generally applicable requirement of a managed care entity described in clause (i) as a condition of payment under subparagraph (A) if such compliance would conflict with any other statutory or regulatory requirements applicable to the Indian health care provider; and

(II) shall only need to comply with those generally applicable requirements of a managed care entity described in clause (i) as a condition of payment under subparagraph (A) that are necessary for the entity’s compliance with the State plan, such as those related to care management,
quality assurance, and utilization management.

"(E) Application of special payment requirements for federally-qualified health centers and encounter rate for services provided by certain Indian health care providers.—

"(i) Federally-qualified health centers.—

"(I) Managed care entity payment requirement.—To agree to pay any Indian health care provider that is a Federally-qualified health center but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a Federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.
“(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a Federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the Federally-qualified health center is or is not a participating provider with the entity).

“(ii) CONTINUED APPLICATION OF ENCOUNTER RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a Federally-qualified health center and that has elected to receive payment under this title as an Indian Health Service provider under the July 11, 1996, Memorandum of Agreement...
between the Health Care Financing Ad-
ministration (now the Centers for Medicare
& Medicaid Services) and the Indian
Health Service for services provided by
such provider to an Indian enrollee with
the managed care entity is less than the
encounter rate that applies to the provision
of such services under such memorandum,
the State plan shall provide for payment to
the Indian health care provider of the dif-
ference between the applicable encounter
rate under such memorandum and the
amount paid by the managed care entity to
the provider for such services.

“(F) CONSTRUCTION.—Nothing in this
paragraph shall be construed as waiving the ap-
lication of section 1902(a)(30)(A) (relating to
application of standards to assure that pay-
mements are consistent with efficiency, economy,
and quality of care).

“(3) OFFERING OF MANAGED CARE THROUGH
INDIAN MEDICAID MANAGED CARE ENTITIES.—If—

“(A) a State elects to provide services
through Medicaid managed care entities under
its Medicaid managed care program; and
“(B) an Indian health care provider that is funded in whole or in part by the Indian Health Service, or a consortium composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Indian Health Service, has established an Indian Medicaid managed care entity in the State that meets generally applicable standards required of such an entity under such Medicaid managed care program,

the State shall offer to enter into an agreement with the entity to serve as a Medicaid managed care entity with respect to eligible Indians served by such entity under such program.

“(4) SPECIAL RULES FOR INDIAN MANAGED CARE ENTITIES.—The following are special rules regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities:

“(A) ENROLLMENT.—

“(i) LIMITATION TO INDIANS.—An Indian Medicaid managed care entity may restrict enrollment under such program to Indians and to members of specific Tribes in the same manner as Indian Health Pro-
grams may restrict the delivery of services
to such Indians and tribal members.

“(ii) No less choice of plans.—
Under such program the State may not
limit the choice of an Indian among Med-
icaid managed care entities only to Indian
Medicaid managed care entities or to be
more restrictive than the choice of man-
aged care entities offered to individuals
who are not Indians.

“(iii) Default enrollment.—

“(I) In general.—If such pro-
gram of a State requires the enroll-
ment of Indians in a Medicaid man-
aged care entity in order to receive
benefits, the State, taking into consid-
eration the criteria specified in sub-
section (a)(4)(D)(ii)(I), shall provide
for the enrollment of Indians de-
scribed in subclause (II) who are not
otherwise enrolled with such an entity
in an Indian Medicaid managed care
entity described in such clause.

“(II) Indian described.—An
Indian described in this subclause,
with respect to an Indian Medicaid 
managed care entity, is an Indian 
who, based upon the service area and 
capacity of the entity, is eligible to be 
enrolled with the entity consistent 
with subparagraph (A).

“(iv) Exception to State Lock-
in.—A request by an Indian who is en-
rolled under such program with a non-In-
dian Medicaid managed care entity to 
change enrollment with that entity to en-
rollment with an Indian Medicaid managed 
care entity shall be considered cause for 
granting such request under procedures 
specified by the Secretary.

“(B) Flexibility in Application of 
Solvency.—In applying section 1903(m)(1) to 
an Indian Medicaid managed care entity—

“(i) any reference to a ‘State’ in sub-
paragraph (A)(ii) of that section shall be 
deemed to be a reference to the ‘Sec-

“(ii) the entity shall be deemed to be 
a public entity described in subparagraph 
(C)(ii) of that section.
“(C) Exceptions to advance directives.—The Secretary may modify or waive the requirements of section 1902(w) (relating to provision of written materials on advance directives) insofar as the Secretary finds that the requirements otherwise imposed are not an appropriate or effective way of communicating the information to Indians.

“(D) Flexibility in information and marketing.—

“(i) Materials.—The Secretary may modify requirements under subsection (a)(5) to ensure that information described in that subsection is provided to enrollees and potential enrollees of Indian Medicaid managed care entities in a culturally appropriate and understandable manner that clearly communicates to such enrollees and potential enrollees their rights, protections, and benefits.

“(ii) Distribution of marketing materials.—The provisions of subsection (d)(2)(B) requiring the distribution of marketing materials to an entire service area shall be deemed satisfied in the case
of an Indian Medicaid managed care entity
that distributes appropriate materials only
to those Indians who are potentially eligi-
ble to enroll with the entity in the service
area.

“(5) MALPRACTICE INSURANCE.—Insofar as,
under a Medicaid managed care program, a health
care provider is required to have medical malpractice
insurance coverage as a condition of contracting as
a provider with a Medicaid managed care entity, an
Indian health care provider that is—

“(A) a Federally-qualified health center
that is covered under the Federal Tort Claims
Act (28 U.S.C. 1346(b), 2671 et seq.);

“(B) providing health care services pursu-
ant to a contract or compact under the Indian
Self-Determination and Education Assistance
Act (25 U.S.C. 450 et seq.) that are covered
under the Federal Tort Claims Act (28 U.S.C.
1346(b), 2671 et seq.); or

“(C) the Indian Health Service providing
health care services that are covered under the
Federal Tort Claims Act (28 U.S.C. 1346(b),
2671 et seq.);

are deemed to satisfy such requirement.
“(6) DEFINITIONS.—For purposes of this sub-
section:

“(A) INDIAN HEALTH CARE PROVIDER.—
The term ‘Indian health care provider’ means
an Indian Health Program or an Urban Indian
Organization.

“(B) INDIAN; INDIAN HEALTH PROGRAM;
SERVICE; TRIBE; TRIBAL ORGANIZATION; URBAN
INDIAN ORGANIZATION.—The terms ‘Indian’,
‘Indian Health Program’, ‘Service’, ‘Tribe’,
‘tribal organization’, ‘Urban Indian Organiza-
tion’ have the meanings given such terms in
section 4 of the Indian Health Care Improve-
ment Act.

“(C) INDIAN MEDICAID MANAGED CARE
ENTITY.—The term ‘Indian Medicaid managed
care entity’ means a managed care entity that
is controlled (within the meaning of the last
sentence of section 1903(m)(1)(C)) by the In-
dian Health Service, a Tribe, Tribal Organiza-
tion, or Urban Indian Organization, or a con-
sortium, which may be composed of 1 or more
Tribes, Tribal Organizations, or Urban Indian
Organizations, and which also may include the
Service.
“(D) Non-Indian Medicaid managed care entity.—The term ‘non-Indian Medicaid managed care entity’ means a managed care entity that is not an Indian Medicaid managed care entity.

“(E) Covered Medicaid managed care services.—The term ‘covered Medicaid managed care services’ means, with respect to an individual enrolled with a managed care entity, items and services that are within the scope of items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

“(F) Medicaid managed care program.—The term ‘Medicaid managed care program’ means a program under sections 1903(m) and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.”.

(b) Application to SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by section 206(b)(2), is amended by adding at the end the following new subparagraph:
“(H) Subsections (a)(2)(C) and (h) of section 1932.”.

SEC. 209. ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by the sections 202, 205, and 206, is amended by redesignating subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

“(e) Annual Report on Indians Served by Health Benefit Programs Funded Under This Act.—Beginning January 1, 2007, and annually thereafter, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service, shall submit a report to Congress regarding the enrollment and health status of Indians receiving items or services under health benefit programs funded under this Act during the preceding year. Each such report shall include the following:

“(1) The total number of Indians enrolled in, or receiving items or services under, such programs, disaggregated with respect to each such program.

“(2) The number of Indians described in paragraph (1) that also received health benefits under programs funded by the Indian Health Service.
“(3) General information regarding the health status of the Indians described in paragraph (1), disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(4) A detailed statement of the status of facilities of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization with respect to such facilities’ compliance with the applicable conditions and requirements of titles XVIII, XIX, and XXI, and, in the case of title XIX or XXI, under a State plan under such title or under waiver authority, and of the progress being made by such facilities (under plans submitted under section 1880(b), 1911(b) or otherwise) toward the achievement and maintenance of such compliance.

“(5) Such other information as the Secretary determines is appropriate.”