To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 4, 2009

Mr. Pallone (for himself, Mr. Rahall, Mr. Kildee, Mr. Young of Alaska, Mr. Grijalva, Ms. Bordallo, Mr. Boren, Mr. Inslee, Mr. Baca, Mr. Heinrich, Mr. Teague, Ms. McCollum, Ms. Linda T. Sánchez of California, Mr. Kagen, Mr. Luján, Mr. Salazar, Mr. Schueller, and Mrs. Bono Mack) introduced the following bill; which was referred to the Committee on Natural Resources, and in addition to the Committees on Energy and Commerce and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Indian Health Care Improvement Act Amendments of 2009”.
(b) **TABLE OF CONTENTS.**—The table of contents of 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.
Sec. 104. GAO study and report on payments for contract health services.

**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. Nondiscrimination in qualifications for payment for services under Federal health care programs.
Sec. 205. Solicitation of proposals for safe harbors under the Social Security Act for facilities of Indian Health Programs and urban Indian organizations.
Sec. 206. Annual report on Indians served by Social Security Act health benefit programs.
Sec. 207. Development of recommendations to improve interstate coordination of Medicaid and SCHIP coverage of Indian children and other children who are outside of their State of residency because of educational or other needs.

**TITLE I—AMENDMENTS TO INDIAN LAWS**

**SEC. 101. INDIAN HEALTH CARE IMPROVEMENT ACT AMENDED.**

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

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

“(a) **SHORT TITLE.**—This Act may be cited as the ‘Indian Health Care Improvement Act’.
“(b) Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title; 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 bonuses.
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.
Sec. 127. Exemption from payment of certain fees.
Sec. 128. Authorization of appropriations.

TITLE II—HEALTH SERVICES

Sec. 201. Indian Health Care Improvement Fund.
Sec. 202. Health promotion and disease prevention services.
Sec. 203. Diabetes prevention, treatment, and control.
Sec. 204. Shared services for long-term care.
Sec. 205. Health services research.
Sec. 206. Mammography and other cancer screening.
Sec. 207. Patient travel costs.
Sec. 208. Epidemiology centers.
Sec. 209. Comprehensive school health education programs.
Sec. 210. Indian youth program.
Sec. 211. Prevention, control, and elimination of communicable and infectious diseases.
Sec. 212. Other authority for provision of services.
Sec. 213. Indian women’s health care.
Sec. 214. Environmental and nuclear health hazards.
Sec. 215. Arizona as a contract health service delivery area.
Sec. 216. 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.
Sec. 225. Office of Indian Men’s Health.
Sec. 226. Authorization of appropriations.

TITLE III—FACILITIES
Sec. 301. Consultation; construction and renovation of facilities; reports.
Sec. 302. Sanitation facilities.
Sec. 303. Preference to Indians and Indian firms.
Sec. 304. Expenditure of 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.
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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.
Sec. 403. Reimbursement from certain third parties of costs of health services.
Sec. 404. Crediting of reimbursements.
Sec. 405. Purchasing health care coverage.
Sec. 406. Sharing arrangements with Federal agencies.
Sec. 407. Eligible Indian veteran services.
Sec. 408. Payor of last resort.
Sec. 409. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services.
Sec. 410. Consultation.
Sec. 411. State Children’s Health Insurance Program (SCHIP).
Sec. 412. Exclusion waiver authority for affected Indian Health Programs and safe harbor transactions under the Social Security Act.

Sec. 413. Premium and cost sharing protections and eligibility determinations under Medicaid and SCHIP and protection of certain Indian property from Medicaid estate recovery.

Sec. 414. Treatment under Medicaid and SCHIP managed care.

Sec. 415. Navajo Nation Medicaid Agency feasibility study.

Sec. 416. Exception for excepted benefits.

Sec. 417. 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. Use of Federal Government Facilities and Sources of Supply.

Sec. 505. Contracts and grants for the determination of unmet health care needs.

Sec. 506. Evaluations; renewals.

Sec. 507. Other contract and grant requirements.

Sec. 508. Reports and records.

Sec. 509. Limitation on contract authority.

Sec. 510. Facilities.

Sec. 511. Division of Urban Indian Health.

Sec. 512. Grants for alcohol and substance abuse-related services.

Sec. 513. Treatment of certain demonstration projects.

Sec. 514. Urban NIAAA transferred programs.

Sec. 515. Conferring with urban Indian organizations.

Sec. 516. Urban youth treatment center demonstration.

Sec. 517. Grants for diabetes prevention, treatment, and control.

Sec. 518. Community health representatives.

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Sec. 602. Automated management information system.

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Sec. 702. Memoranda of agreement with the Department of the Interior.

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Sec. 706. Indian women treatment programs.

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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. 715. Behavioral health research.

"Sec. 716. Definitions.

"Sec. 717. Authorization of appropriations.

"TITLE VIII—MISCELLANEOUS

"Sec. 801. Reports.

"Sec. 802. Regulations.

"Sec. 803. Plan of implementation.

"Sec. 804. Limitation on use of funds appropriated to Indian Health Service.

"Sec. 805. Eligibility of California Indians.

"Sec. 806. Health services for ineligible persons.

"Sec. 807. Treatment of certain services and benefits.

"Sec. 808. Reallocation of base resources.

"Sec. 809. Results of demonstration projects.

"Sec. 810. Provision of services in Montana.

"Sec. 811. Moratorium.

"Sec. 812. Severability provisions.

"Sec. 813. Use of patient safety organizations.

"Sec. 814. Confidentiality of medical quality assurance records; qualified immu-

"nity for participants.

"Sec. 815. Claremore Indian Hospital.

"Sec. 816. Sense of Congress regarding law enforcement and methamphetamine

issues in Indian country.

"Sec. 817. Permitting implementation through contracts with Tribal Health

Programs.

"Sec. 818. Authorization of appropriations; availability.

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 his-
torical and unique legal relationship with, and re-
sulting responsibility to, the American Indian people.

4 "(2) A major national goal of the United States

is to provide the resources, processes, and structure

that will enable Indian tribes and tribal members to

obtain the quantity and quality of health care serv-
ices and opportunities that will eradicate the health
disparities between Indians the general population.

“(3) A major national goal of the United States
is to provide the quantity and quality of health serv-
ices which will permit the health status of Indians
to be raised to the highest possible level and to en-
courage the maximum participation of Indians in the
planning and management of those services.

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

“(5) 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 POL-
ICY.

“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 to at least the levels set forth in the goals contained within the Health 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 na-
tional or regional organization with accrediting au-

“(2) The term ‘Area Office’ means an adminis-

trative entity, including a program office, within the

Service through which services and funds are pro-

vided to the Service Units within a defined geo-

graphic area.

“(3) The term ‘Assistant Secretary’ means the

Assistant Secretary of Indian Health.

“(4)(A) The term ‘behavioral health’ means the

blending of substance (including alcohol, drugs,
inhalants, and tobacco) abuse and mental health

prevention and treatment, for the purpose of pro-

viding 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.

“(5) The term ‘California Indians’ means those

Indians who are eligible for health services of the

Service pursuant to section 805.

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

“(A) a tribal college or university, or

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

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

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

“(A) controlling—

“(i) 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, naturopathic medicine, 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) reproductive health and family planning;

“(xx) safe and adequate water;

“(xxi) healthy work environments;

“(xxii) elimination, reduction, and prevention of contaminants that create unhealthy household conditions (including mold and other allergens);

“(xxiii) stress control;

“(xxiv) substance abuse;

“(xxv) sanitary facilities;

“(xxvi) sudden infant death syndrome prevention;
“(xxvii) tobacco use cessation and reduction;

“(xxviii) violence prevention; and

“(xxix) activities 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 805, 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 member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or

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

“(B) is an Eskimo or Aleut or other Alaska 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 directly by the Service;

“(B) any Tribal Health Program; or

“(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of 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(f) of the Higher Education Act of 1965 (20 U.S.C. 1058(f)).

“(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 (43 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 geo-
graphical area served by each Area Office.

“(20) The term ‘Service Unit’ means an admin-
istrative entity of the Service, or a Tribal Health
Program through which services are provided, di-
rectly or by contract, to eligible Indians within a de-
fined 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 tele-
communications 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 infor-
mation in audio, video, graphic, or other format for
the purpose of providing improved health care serv-
ices.
“(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-Determination 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 de-
scendant 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 situ-
ated in an Urban Center; (B) is governed by an
Urban Indian-controlled board of directors; (C) pro-
vides 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.—No grant may be made 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 reim-
bursement, and at such intervals and on such condi-
tions 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 SCHOL-
ARSHIP 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 suc-
cessfully complete courses of study in the health pro-
fessions.

“(b) PURPOSES.—Scholarship grants provided pursu-
ant to this section shall be for the following purposes:

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

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

“(c) OTHER CONDITIONS.—Scholarships under this section—

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

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

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

“SEC. 104. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

“(a) IN GENERAL.—

“(1) AUTHORITY.—The Secretary, acting through the Service, shall make scholarship grants to Indians who are enrolled full or part time in accredited schools pursuing courses of study in the health professions. Such scholarships shall be desi-
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 provided in subsection (b) of this section.

“(2) Determinations by Secretary.—The Secretary, acting through the Service, shall determine—

“(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 Assistant Secretary 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 Secre-
etary, in accordance with guidelines promul-
gated by the Secretary, such practice is situated
in a physician or other health professional
shortage area and addresses the health care
needs of a substantial number of Indians.

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

“(2) OBLIGATION DEFERRED.—At the request
of any individual who has entered into a contract re-
ferred to in paragraph (1) and who receives a degree
in medicine (including osteopathic or allopathic med-
icine), dentistry, optometry, podiatry, or pharmacy,
the Secretary shall defer the active duty service obli-
gation of that individual under that contract, in
order that such individual may complete any intern-
ship, residency, or other advanced clinical training
that is required for the practice of that health pro-
fession, for an appropriate period (in years, as deter-
mined by the Secretary), subject to the following
conditions:

“(A) No period of internship, residency, or
other advanced clinical training shall be counted
as satisfying any period of obligated service
under this subsection.

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

“(C) The active duty service obligation will
be served in the health profession of that indi-
vidual 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 speci-
fied under that paragraph that—
“(i) is located on the reservation of the Indian Tribe in which the recipient is enrolled; or

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

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

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

“(1) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the 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 specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254l(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

“(d) BREACH OF CONTRACT.—

“(1) SPECIFIED BREACHES.—An individual shall be liable to the United States for the amount which has been paid to the individual, or on behalf of the individual, under a contract entered into with the Secretary under this section on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 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 sus-
pension 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 pay-
ment;

“(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.—

When waiving or suspending an obligation of service or payment under subparagraph (A), the Secretary shall consult with the Area Office, In-
dian Tribes, Tribal Organizations, or urban In-
dian organizations affected to consider whether the obligation may be satisfied in a teaching ca-
pacity at a tribal college or university nursing program under subsection (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 Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

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

“SEC. 105. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

“(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians 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 subsection (a) to develop and maintain a program at the University of North Dakota to be known as the ‘Quentin N. Burdick American Indians Into Psychology Program’. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs authorized under section 117(b), the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115(e), and existing university research and communications networks.

“(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of 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 affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

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

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

“(e) ACTIVE DUTY SERVICE REQUIREMENT.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (d)(4) that is funded under this section. Such obligation shall be met by service—
“(1) in an Indian Health Program;
“(2) in a program assisted under title V of this Act; or
“(3) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.
“(f) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $2,700,000 for each of fiscal years 2010 through 2025.

“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 con-
tain 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 scholar-
ship shall be paid from the funds made avail-
able pursuant to subsection (a)(1) provided to
the Tribal Health Program; and

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

“(c) COURSE OF STUDY.—A Tribal Health Program shall provide scholarships under this section only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in 1 of the health pro-
fessions 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 scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

“(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to each health profession.
“(3) Service in other service areas.—The contract may allow the recipient to serve in another Service Area, provided the Tribal Health Program and Secretary approve and services are not diminished to Indians in the Service Area where the Tribal Health Program providing the scholarship is located.

“(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 con-
tract before the completion of such training; or

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

“(2) OTHER BREACHES.—If for any reason not
specified in paragraph (1), an individual breaches a
written contract by failing to either begin such indi-
vidual’s service obligation required under such con-
tract 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 RECIPI-
ENT.—Upon the death of an individual who receives
an Indian Health Scholarship, any outstanding obli-
gation 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 re-
ceived 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 re-
ipient of a scholarship under this section shall agree, in
providing health care pursuant to the requirements here-
in—

“(1) not to discriminate against an individual
seeking care on the basis of the ability of the 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-
rit-y 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 employed shall not be counted against any employment ceiling affecting the Service or the Department.

“SEC. 108. CONTINUING EDUCATION ALLOWANCES.

“In order to encourage scholarship and stipend recipients 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 Service, may—

“(1) provide programs or allowances to transition into an Indian Health Program, including licensing, 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 PRO-
GRAM.
“(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 Representa-
tive Program under which Indian Health Programs—
“(1) provide for the training of Indians as com-
munity health representatives; and
“(2) use such community health representatives
in the provision of health care, health promotion,
and disease prevention services to Indian commu-
nities.
“(b) DUTIES.—The Community Health Representa-
tive 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 Serv-
ice 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 pro-
gram 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 accredi-
tation of, and provide health care services to Indians
through, Indian Health Programs and urban Indian orga-
izations.

“(b) ELIGIBLE INDIVIDUALS.—To be eligible to par-
ticipate 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 deter-
mimed by the Secretary under section
338B(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 254l–1(b)(1)(c)(i))) 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).

“(e) 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 (k) in the case of the individual’s breach of contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Service to enable the individual to make a decision on an informed basis.

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

“(3) TIMELY AVAILABILITY OF FORMS.—The Secretary shall make such application forms, 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 (j), 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 pri-
ority.

“(2) APPROVALS.—Notwithstanding the pri-
ority determined under paragraph (1), the Secretary,
in determining which applications under the Loan
Repayment Program to approve (and which con-
tracts 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

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“(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 Pro-
gram or urban Indian organization as provided in clause (ii)(III); and

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

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

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

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

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

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

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

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

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

“(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.
“(f) Deadline for Decision on Application.—

The Secretary shall provide written notice to an individual within 21 days on—

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

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

“(g) Payments.—

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

“(A) tuition expenses;

“(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and
“(C) reasonable living expenses as determined by the Secretary.

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

“(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 contracts;

“(B) provides an incentive to serve in Indian Health Programs and urban Indian organizations 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 organi-
zation with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

“(3) Timing.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

“(4) 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 repayments made for the taxable year involved; and

“(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.
“(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

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

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

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

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

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

“(l) BREACH OF CONTRACT.—

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

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

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

“(ii) voluntarily terminates such enrollment; or

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

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

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

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

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

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

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

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

“(4) **DEDUCTIONS IN MEDICARE PAYMENTS.**—
Amounts not paid within such period shall be sub-
ject to collection through deductions in Medicare
payments pursuant to section 1892 of the Social Se-
curity Act.

“(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) Waiver or Suspension of Obligation.—

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

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

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

“(4) BANKRUPTCY.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under 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 sections 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 organi-
zations for which recruitment or retention is dif-

“SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOV-
ERY 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 pro-
gram participant under section 110 has been
assigned to meet the obligated service requirements pursuant to such sections; and

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

“(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 Indian Health Programs and urban Indian organizations to recruit, place, and retain health professionals to meet their staffing needs.

“(b) Eligible Entities; Application.—Any Indian Health Program or Urban Indian organization may submit an application for funding of a project pursuant to this section.
“SEC. 114. ADVANCED TRAINING AND RESEARCH.

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

“(b) Service Obligation.—An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 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, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

“(f) ACTIVE DUTY SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or 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-Deter-
mination 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 pro-
gram 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 Psy-
chology Program established under section 105(b) and the
Quentin N. Burdick American Indians Into Nursing Pro-
gram 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 pro-
vided under this section shall agree to provide a program
which—

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

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

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

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

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

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

“(a) Grants To Establish Programs.—

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

“(2) Amount of Grants.—The amount of any
grant awarded to a community college under para-
graph (1) for the first year in which such a grant
is provided to the community college shall not exceed
$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).

“(e) 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 incurred as a requirement of—

“(i) any Federal scholarship program; or

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

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

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

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

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

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

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

“SEC. 120. NURSING RESIDENCY PROGRAM.

“(a) Establishment of Program.—The Sec-
retary, acting through the Service, shall establish a pro-
gram to enable Indians who are licensed practical nurses,
licensed vocational nurses, and registered nurses who are
working in an Indian Health Program or urban Indian
organization, and have done so for a period of not less
than 1 year, to pursue advanced training. Such program
shall include a combination of education and work study
in an Indian Health Program or urban Indian organiza-
tion leading to an associate or bachelor’s degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor’s degree (in the case of a registered nurse), or advanced degrees 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 technicians), 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, act-
ing through the Service, shall develop and operate a Com-
munity 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 pro-
vision of health care, health promotion, and disease
prevention services to Alaska Natives living in vil-
lages in rural Alaska; and
“(3) provides for the establishment of tele-
conferencing 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 Sec-
retary, acting through the Community Health Aide Pro-
gram 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 Pro-
gram;
“(2) in order to provide such training, develop
a curriculum that—
“(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

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

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

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

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

“(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the provision of quality health care, health promotion, and disease prevention services; 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 dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment, and further that dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, provided that uncomplicated extractions shall not be considered oral surgery 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 neutral 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 Natural 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 shall, by contract or otherwise, provide training for individuals in the administration and planning of Tribal Health Programs, with priority to Indians.

“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.

“(a) No Reduction in Services.—The Secretary shall not—

“(1) remove a member of the National Health Service Corps from an Indian Health Program or urban Indian organization; or
“(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

“(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—

At the request of an Indian Health Program, the services of a member of the National Health Service Corps assigned to an Indian Health Program may be limited to the persons who are eligible for services from such Program.

“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 2009, 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 fis-
cal year, a report on the findings and conclusions derived from the demonstration programs conducted under this section during that fiscal year.

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

“(1) Classroom education.

“(2) Clinical work experience.

“(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 consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and self-destructive behavior.

“(b) POSITIONS.—The positions referred to in subsection (a) are—

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

“(A) elementary and secondary education;
“(B) social services and family and child welfare;

“(C) law enforcement and judicial services;

and

“(D) alcohol and substance abuse;

“(2) staff positions within the Service; and

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

“(c) TRAINING CRITERIA.—

“(1) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or urban Indian organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assist-
ance 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 2009, 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. EXEMPTION FROM PAYMENT OF CERTAIN FEES.

“Employees of a Tribal Health Program or an Urban Indian Organization shall be exempt from payment of licensing, registration, and other fees imposed by a Federal agency to the same extent that Commissioned Corps Officers or other employees of the Indian Health Service are exempt from such fees.

“SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2025 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, including data collection and evaluation, demonstration projects, training, and capacity building.

“(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 determination of the extent of the health status and resource deficiency of such Indian Tribe or Tribal Organization.

“(e) ELIGIBILITY FOR FUNDS.—Tribal Health Programs 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 2009, 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-
dian Tribes served by the Service or a Tribal Health
Program; and

“(4) an estimate of—

“(A) the amount of health service funds
appropriated under the authority of this Act, or
any other Act, including the amount of any
funds transferred to the Service for the pre-
ceeding fiscal year which is allocated to each 
Service Unit, Indian Tribe, or Tribal Organiza-
tion; 
“(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 wait-
ing lists and number of Indians turned away for 
services due to lack of resources. 
“(g) INCLUSION IN BASE BUDGET.—Funds appro-
priated under this section for any fiscal year shall be in-
cluded in the base budget of the Service for the purpose 
of determining appropriations under this section in subse-
quent fiscal years. 
“(h) CLARIFICATION.—Nothing in this section is in-
tended to diminish the primary responsibility of the Serv-
vice to eliminate existing backlogs in unmet health care 
needs, nor are the provisions of this section intended to 
discourage the Service from undertaking additional efforts 
to achieve equity among Indian Tribes and Tribal Organi-
zations.
“(i) FUNDING DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the ‘Indian Health Care Improvement Fund’.

“SEC. 202. 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, 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. 203. 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 control 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 2009.

“(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 inci-
ence 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 establish and maintain in each Area Office a position of diabetes control officer to coordinate and manage any activity of that Area Office relating to the prevention, treatment, or control of diabetes 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. 254c-3).

“(B) CERTAIN ACTIVITIES.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.
“SEC. 204. 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).

“(e) 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. 205. 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. 206. MAMMOGRAPHY AND OTHER CANCER SCREENING.

“The Secretary, acting through the Service, 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. 207. 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 be-
cause 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 applica-
table Indian Health Program determines to be appro-
riate.

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

“(1) emergency air transportation and non-
emergency air transportation where ground trans-
portation 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 ve-
hicle transportation is not available.
“SEC. 208. EPIDEMIOLOGY CENTERS.

“(a) Establishment of Centers.—The Secretary shall establish an epidemiology center in each Service Area to carry out the functions described in subsection (b). Any new center established after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.

“(b) Functions of Centers.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian communities, each Service Area epidemiology center established under this section 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 communities in the Service Area;

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

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

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

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

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

“(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian communities 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 section.

“(d) GRANTS FOR STUDIES.—

“(1) IN GENERAL.—The Secretary may make grants to Indian Tribes, Tribal Organizations, Indian organizations, and eligible intertribal consortia
to conduct epidemiological studies of Indian communities.

“(2) Eligible intertribal consortia.—An intertribal consortium or Indian organization is eligible to receive a grant under this subsection if—

“(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

“(B) the intertribal consortium is representative of the Indian Tribes or urban Indian communities in which the intertribal consortium is located.

“(3) Applications.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

“(4) Requirements.—An applicant for a grant under this subsection shall—

“(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

“(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and
“(C) demonstrate cooperation from Indian Tribes or Urban Indian Organizations in the area to be served.

“(5) USE OF FUNDS.—A grant awarded under paragraph (1) may be used—

“(A) to carry out the functions described in subsection (b);

“(B) to provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff on health care and health service management issues; and

“(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

“(e) ACCESS TO INFORMATION.—

“(1) An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996, as such entities are defined in part 164.501 of title 45, Code of Federal Regulations.
“(2) The Secretary shall grant to such epidemiology center access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

“(3) The activities of such an epidemiology center shall be for the purposes of research and for preventing and controlling disease, injury, or disability for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such activities are described in part 164.512 of title 45, Code of Federal Regulations (or a successor regulation).

“(f) FUNDS NOT DIVISIBLE.—An epidemiology center established under this section shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for such center shall not be divisible.

“SEC. 209. 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 and Tribal Organizations to develop com-
prehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of 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 and Tribal 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 and Tribal 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, 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. 210. 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. 211. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

“(a) Grants authorized.—The Secretary, acting through the Service, and after consultation with the Cen-
HHS, Centers for Disease Control and Prevention, may make grants 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 encour-
aged 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. 212. OTHER AUTHORITY FOR PROVISION OF 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 of this Act through health care-related services and programs not otherwise described in this Act for the following services:

“(1) Hospice care.

“(2) Assisted living services.

“(3) Long-term care services.
“(4) Home- and community-based services.

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

“(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

“(2) Individuals with a mental impairment, such as dementia, Alzheimer’s disease, or another disabling mental illness, who may be able to perform activities of daily living under supervision.

“(3) Such other individuals as an applicable Indian Health Program determines to be appropriate.

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

“(1) The term ‘assisted living services’ means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility—

“(A) shall not be required to obtain a license; but

“(B) shall meet all applicable standards for licensure.

“(2) The term ‘home- and community-based services’ means 1 or more of the services specified
in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

“(3) 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.

“(4) The term ‘long-term care services’ has the meaning given the term ‘qualified long-term care services’ in section 7702B(c) of the Internal Revenue Code of 1986.

“(d) Authorization of Convenient Care Services.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).
“SEC. 213. INDIAN WOMEN’S HEALTH CARE.

“The Secretary, acting through the Service, 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. 214. 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 In-
dian Health Care Improvement Act Amendments of
2009 that directly or indirectly relate to the activi-
ties, practices, and conditions affecting the health or
safety of such Indians; and

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

“(b) HEALTH CARE PLANS.—Upon completion of such studies, the Secretary and the Service shall take into account the results of such studies and 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 2009. 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 environ-
mental hazard, the Indian Health Program shall, at
the request of such Indian, render appropriate med-
icare to such Indian for such illness or condition
and may be reimbursed for any medical care so ren-
dered to which such Indian is entitled at the expense
of such operator or entity from such operator or en-
tity. 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. 215. ARIZONA AS A CONTRACT HEALTH SERVICE DE-
LIVERY AREA.

“(a) IN GENERAL.—For fiscal years beginning with
the fiscal year ending September 30, 1983, and ending
with the fiscal year ending September 30, 2025, the State
of Arizona shall be designated as a contract health service
delivery area by the Service for the purpose of providing
contract health care services to members of federally rec-
ognized Indian Tribes of Arizona.

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

“SEC. 216. 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 designation 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 im-
prove 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 805(a) throughout the California contract health services delivery area described in section 219 with respect to high cost contract care cases.

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

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

“(e) Advisory Board.—There is established an advisory board which shall advise the CRIHB in carrying out this section. The advisory board shall be composed of
representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least ½ of whom of whom are not affiliated with the CRIHB.

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

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

“SEC. 219. CONTRACT HEALTH SERVICES FOR THE 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, functions, services, activities, information technology, and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs, functions, services, activities, information technology, and facilities operated directly by the Service.

“SEC. 221. LICENSING.

“Licensed 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.) while performing such services.
“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 224(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 2009, 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 2025 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 applica-
ble, that such facility meets the construction stand-
ards of any accrediting body recognized by the Sec-
retary 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 ren-
ovation of such facility is completed.

“(b) CLOSURES.—

“(1) EVALUATION REQUIRED.—Notwith-
standing any other provision of law, no facility oper-
ated by the Service may be closed if the Secretary 
has not submitted to Congress, not less than 1 year 
and not more than 2 years before the date of the 
proposed closure, an evaluation, completed not more 
than 2 years before such submission, of the impact 
of the proposed closure that 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, environmental, or construction safety reasons.

“(c) Health Care Facility Priority System.—

“(1) In General.—

“(A) Priority System.—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 Organizations;
“(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 required in paragraph (2)(B)(v); and

“(III) may include such other facilities, and such renovation or expansion needs of any health care facility, as the Service, Indian Tribes, and Tribal Organizations may identify; and

“(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian 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 established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 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 2008 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 Secretary; or

“(II) pursuant to a request of an Indian Tribe or Tribal Organization.

“(2) REPORT; CONTENTS.—

“(A) INITIAL COMPREHENSIVE REPORT.—

“(i) DEFINITIONS.—In this subparagrap:

“(I) FACILITIES APPROPRIATION ADVISORY BOARD.—The term ‘Facilities Appropriation Advisory Board’ means the advisory board, comprised
of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Assistant Secretary—

“(aa) to provide advice and recommendations for policies and procedures of the programs funded pursuant to facilities appropriations; and

“(bb) to address other facilities issues.

“(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term ‘Facilities Needs Assessment Workgroup’ means the workgroup established at the discretion of the Assistant Secretary—

“(aa) to review the health care facilities construction priority system; and

“(bb) to make recommendations to the Facilities Appropriation Advisory Board for revising the priority system.

“(ii) INITIAL REPORT.—
“(I) In general.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian Tribes, and Tribal Organizations (including inpatient health care facilities, outpatient health care facilities, specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, staff quarters and hostels associated with health care facilities, 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 Appropriation Advisory Board.

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

“(aa) the methodology and criteria used by the Service in determining the needs and establishing the ranking of the facilities needs; and

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

“(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, 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 Con-
gress 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 (e)(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 (e)(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 Natural 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 attributable 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 organiza-
tions which operate and maintain sanitation facili-
ties.

“(3) Priority funding for operation and mainte-
nance assistance for, and emergency repairs to, sani-
tation 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 provi-
sion of law—

“(1) the Secretary of Housing and Urban De-
development is authorized to transfer funds appro-
priated under the Native American Housing Assist-
4101 et seq.) to the Secretary of Health and Human
Services;

“(2) the Secretary of Health and Human Serv-
ices 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 fund up to 100 percent of the amount of an Indian Tribe’s loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

“(6) except as otherwise prohibited by this section, the Secretary may use funds appropriated under the authority of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), to meet matching or cost participation requirements under other Fed-
eral and non-Federal programs for new projects to construct eligible sanitation facilities;

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

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

“(9) 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

“(10) 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

“(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 in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (h)(1)(F).

“(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-
assist the Indian Tribe, Tribal Organization, or Indian community in the resolution of the problem on a short-term basis through cooperation with the emergency coordinator or by providing operation, management, and maintenance service.

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

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

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

“(h) REPORT.—

“(1) REQUIRED; CONTENTS.—The Secretary, in consultation with the Secretary of Housing and Urban Development, Indian Tribes, Tribal Organizations, and tribally designated housing entities (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) shall submit to the President, for inclusion in 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 washeteria or central facility exists in the community.

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

“(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) PAY RATES.—For the purposes of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a-5, known as the Davis-Bacon Act).

“(c) LABOR STANDARDS.—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 in-
frastructure, 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’).

SEC. 304. EXPENDITURE OF NON-SERVICE FUNDS FOR
RENOVATION.

“(a) IN GENERAL.—Notwithstanding any other pro-
vision 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 moderniza-
tion by any Indian Tribe or Tribal Organization of any
Service facility or of any other Indian health facility oper-
ated 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 moderniza-
tion 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 Sec-
retary with respect to construction or renewa-
tion 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 pur-
suant to regulations, including additional staffing, equip-
ment, 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, renewa-
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, renovation, or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation, or modernization.

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

“(a) GRANTS.—

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

“(2) 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 306; 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(c)(2).

“(2) ADDITIONAL ALLOWABLE USE.—The Sec-
retary may also reserve a portion of the funding pro-
vided under this section and use those reserved
funds to reduce an outstanding debt incurred by In-
dian Tribes or Tribal Organizations for the con-
struction, expansion, or modernization of an ambula-
tory 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 bene-
fits the Service population identified above in sub-
section (b)(1)(C) (ii) and (iii). The requirements of
clauses (ii) and (iii) of paragraph (1)(C) shall not
apply to an Indian Tribe or Tribal Organization ap-
plying for a grant under this section for a health
care facility located or to be constructed on an is-
land 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 popu-
lation.

“(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-Deter-
mination and Education Assistance Act (25 U.S.C. 450 et seq.) or for reallocation or redesign thereunder.

``SEC. 306. INDIAN HEALTH CARE DELIVERY DEMONSTRA-
TION PROJECT.

“(a) Health Care Demonstration Projects.—The Secretary, acting through the Service, is authorized to make grants to, and enter into construction contracts or construction project agreements with, Indian Tribes or Tribal Organizations under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for the purpose of carrying out a health care delivery demon-
stration 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 such con-
tracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to de-
deliver health care services and is authorized to—

“(1) waive any leasing prohibition;

“(2) permit carryover of funds appropriated for the provision of health care services;

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

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

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

“(c) REGULATIONS.—The Secretary shall develop and promulgate regulations, not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, for the review and approval 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 program or the reorientation of an existing facility or program.

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

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

“(4) The project is economically viable.

“(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.
“(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

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

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

“(1) Cass Lake, Minnesota.
“(2) Mescalero, New Mexico.
“(3) Owyhee, Nevada.
“(4) Schurz, Nevada.
“(5) 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 806, 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 806 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 Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

**SEC. 307. LAND TRANSFER.**

“Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the 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 Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for compensation to the Indian Tribe or Tribal Organization of rental and other costs consistent with section 105(l) of the Indian Self-Determination and Education Assistance Act (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 guar-
antees for loans for the construction of health care facilities, including—

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

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

“(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

“(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

“(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;
“(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund;

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

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

“(7) whether, in the planning and design of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

“(8) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

“(9) the appropriateness of, and best methods for, coordinating the loan fund with the health care priority system of the Service under section 301; and
“(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

“(c) REPORT.—Not later than September 30, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural 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 demonstration projects under which an Indian Tribe or Tribal Organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health
facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility. An Indian Tribe or Tribal Organization may use tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under a joint venture entered into under this subsection. An Indian Tribe or Tribal Organization shall be eligible 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;

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

“(3) in its application for a joint venture agreement, agrees—

“(A) to construct a facility for the joint venture which complies with the size and space criteria established by the Service; or

“(B) if the facility it proposes for the joint venture is already in existence or under construction, that only the portion of such facility which complies with the size and space criteria
of the Service will be eligible for the joint venture agreement.

“(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 village, or village or regional corporation under the Alaska Native Claims Settlement Act (43 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 Indian Tribe or Tribal Organization. Top priority shall be given to Indian land owned by 1 or more Indian Tribes.

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

“(1) all lands within the exterior boundaries of any reservation; 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 transmitted to Congress under section 801, a report which identifies the backlog of maintenance and repair work required at both Service and tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The report shall also identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

“(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and improvement funds to support maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the 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 improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The Secretary shall
consult with Indian Tribes and Tribal Organizations in determining the maximum renovation cost threshold.

“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.

“(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 discre-
tion 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 employ-
ees 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

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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) Transferred Funds.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

“(d) Establishment of Standards.—The Secretary, through the Service, shall establish standards by regulation 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 2025 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 provi-
sion of title XVIII or XIX of the Social Secu-
rity 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 either such title.

“(B) USE OF FUNDS.—Amounts received
by a facility of the Service under subparagraph
(A) by reason of a provision of title XVIII or
XIX of the Social Security Act 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 fa-
cility which may be necessary to achieve or
maintain compliance with the applicable condi-
tions and requirements of such respective title.
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 increasing the facility’s capacity to provide, or improving the quality or accessibility of, services.

“(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, XIX, or XXI of the Social Security Act.

“(2) DIRECT REIMBURSEMENT.—

“(A) USE OF FUNDS.—Each Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI 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 same purposes with respect to such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service may be used pursuant to subparagraph (B) of such subsection with respect to the Service.

"(B) AUDITS.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian Health Program. Nothing in the preceding sentence shall be construed as limiting the application of auditing 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 title XIX or XXI 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 regarding 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 program established under this subsection may withdraw from participation in the same manner and under the same conditions that an Indian Tribe or Tribal Organization may retrocede a contracted program to the Secretary under the authority of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this subsection shall be returned to the Secretary upon the Secretary’s acceptance of the withdrawal of participation in this program.

“(5) Termination for Failure to Comply with Requirements.—The Secretary may terminate 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 re-
requirement and a reasonable opportunity to correct
such noncompliance prior to terminating the Pro-
gram’s participation in the direct billing program es-
tablished under this subsection.

“(e) RELATED PROVISIONS UNDER THE SOCIAL SE-
CURITY 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 SERV-
ICE, INDIAN TRIBES, TRIBAL ORGANIZA-
TIONS, AND URBAN INDIAN ORGANIZATIONS
TO FACILITATE OUTREACH, ENROLLMENT,
AND COVERAGE OF INDIANS UNDER SOCIAL
SECURITY ACT HEALTH BENEFIT PROGRAMS.

“(a) INDIAN TRIBES AND TRIBAL ORGANIZA-
TIONS.—From funds appropriated to carry out this title
in accordance with section 414, 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 estab-
lishing and administering programs on or near reserva-
tions and trust lands, including programs to provide out-
reach and enrollment through video, electronic delivery
methods, or telecommunication devices that allow real-
time or time-delayed communication between individual
Indians and the benefit program, to assist individual Indi-
ans—

“(1) to enroll for benefits under a program es-
tablished under title XVIII, XIX, or XXI of the So-
cial Security Act; 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 de-
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 Trib-
al 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 eli-
gible 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 in Enrollment and Retention.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall consult with States, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to develop and disseminate best practices with respect to facilitating agreements between the States and Indian Tribes, Tribal Organizations, and urban Indian organizations relating to enrollment and retention of Indians in programs established under titles XVIII, XIX, and XXI of the Social Security Act.

“(e) Agreements to Improve Enrollment of Indians Under Social Security Act Health Benefits Programs.—For provisions relating to agreements between the Secretary and the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and 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) DEFINITIONS.—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.

“(3) BENEFITS.—The term ‘benefits’ means, with respect to—

“(A) title XVIII of the Social Security Act, benefits under such title;

“(B) title XIX of such Act, medical assistance under such title; and

“(C) title XXI of such Act, assistance under such title.

“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 charges billed by the Secretary, an Indian Tribe, or Tribal Organization, or, if higher, the highest amount
the third party would pay for care and services furnished by providers other than governmental entities, 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 if—

“(1) such services had been provided by a nongovernmental provider; and

“(2) such individual had been required to pay such charges or expenses and did pay such charges or expenses.

“(b) Limitations on Recoveries From States.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

“(1) workers’ compensation laws; or

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

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

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

“(e) ENFORCEMENT.—
“(1) IN GENERAL.—The United States, an Indian Tribe, or Tribal Organization may enforce the right of recovery provided under subsection (a) by—
“(A) intervening or joining in any civil action or proceeding brought—
“(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization; or
“(ii) by any representative or heirs of such individual, or
“(B) instituting a civil action, including a civil action for injunctive relief and other relief and including, with respect to a political 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.

“(3) RECOVERY FROM TORTFEASORS.—

“(A) IN GENERAL.—In any case in which an Indian Tribe or Tribal Organization that is authorized or required under a compact or contract issued pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) to furnish or pay for health services to a person who is injured or suffers a disease on or after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 under circumstances that establish grounds for a claim of liability against the tortfeasor with respect to the injury or disease, the Indian Tribe or Tribal Organization shall have a right to recover from the tortfeasor (or an insurer of the tortfeasor) the reasonable value of the health services so furnished, paid for, or to be paid for, in accordance with the
Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), to the same extent and under the same circumstances as the United States may recover under that Act.

“(B) TREATMENT.—The right of an Indian Tribe or Tribal Organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian Tribe or Tribal Organization.

“(f) LIMITATION.—Absent specific written authorization by the governing body of an Indian Tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal Organization, or urban Indian organization. Where such authorization is provided, the Service may receive and expend such amounts for the provision of additional health services consistent with such authorization.

“(g) COSTS AND ATTORNEYS’ FEES.—In any action brought to enforce the provisions of this section, a 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-


rity 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
Social Security Act or recognized under section 1175 of
such Act.

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

“(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 ref-
ereces 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.

“SEC. 404. CREDITING OF REIMBURSEMENTS.

“(a) RETENTION OF AMOUNTS FOR USE BY PROGRAM.—Except as provided in section 202(f) (relating to the Catastrophic Health Emergency Fund) and section 806 (relating to health services for ineligible persons), all reimbursements received or recovered, including under section 806, 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.

“(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) PURCHASING COVERAGE.—

“(1) 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 that qualifies as creditable coverage under section 2701(c)(1) of the Public Health Service Act for such beneficiaries, including, subject to paragraph (2), through—

“(A) a tribally owned and operated health care plan;

“(B) a State or locally authorized or licensed health care plan;

“(C) a health insurance provider or managed care organization; or

“(D) a self-insured plan.
“(2) Exception.—The coverage provided under paragraph (1) may not include coverage consisting of—

“(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

“(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

“(3) Permitting Purchase of Coverage Based on Financial Need.—The purchase of coverage by an Indian Tribe, Tribal Organization, or urban Indian organization under this subsection may be based on the financial needs of beneficiaries (as determined by the Indian Tribe or Tribes being served based on a schedule of income levels developed or implemented by such Indian Tribe or Tribes).

“(b) Expenses for Self-Insured Plan.—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan,
including administration and insurance to limit the financial risks to the entity offering the plan.

“(c) CONSTRUCTION.—Nothing in this section shall be construed as affecting the use of any amounts not referred to in subsection (a).

“SEC. 406. SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

“(a) AUTHORITY.—

“(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs and the Department of Defense.

“(2) CONSULTATION BY SECRETARY REQUIRED.—The Secretary may not finalize any arrangement between the Service and a Department described in paragraph (1) without first consulting with the Indian Tribes which will be significantly affected by the arrangement.

“(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—
“(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

“(2) the quality of health care services provided to any Indian through the Service;

“(3) the priority access of any veteran to health care services provided by the Department of Veterans Affairs;

“(4) the quality of health care services provided by the Department of Veterans Affairs or the Department of Defense; or

“(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs.

“(c) REIMBURSEMENT.—The Service, Indian Tribe, or Tribal Organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian Tribe, or a Tribal Organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

“(d) CONSTRUCTION.—Nothing in this section may be construed as creating any right of a non-Indian veteran to obtain health services from the Service.
“SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

“(a) FINDINGS; PURPOSE.—

“(1) FINDINGS.—Congress finds that—

“(A) collaborations between the Secretary and the Secretary of Veterans Affairs regarding the treatment of Indian veterans at facilities of the Service should be encouraged to the maximum extent practicable; and

“(B) increased enrollment for services of the Department of Veterans Affairs by veterans who are members of Indian tribes should be encouraged to the maximum extent practicable.

“(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the document entitled ‘Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service’ and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Service).

“(b) DEFINITIONS.—In this section:

“(1) ELIGIBLE INDIAN VETERAN.—The term ‘eligible Indian veteran’ means an Indian or Alaska Native veteran who receives any medical service that is—

“(A) authorized under the laws administered by the Secretary of Veterans Affairs; and
“(B) administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) pursuant to a local memorandum of understanding.

“(2) Local memorandum of understanding.—The term ‘local memorandum of understanding’ means a memorandum of understanding between the Secretary (or a designee, including the director of any Area Office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled ‘Memorandum of Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service’ and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

“(c) Eligible Indian Veterans’ Expenses.—

“(1) In general.—Notwithstanding any other provision of law, the Secretary shall provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).
“(2) Method of payment.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

“(d) Tribal approval of memoranda.—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

“(e) Funding.—

“(1) Treatment.—Expenses incurred by the Secretary in carrying out subsection (c)(1) shall not be considered to be Contract Health Service expenses.

“(2) Use of funds.—Of funds made available to the Secretary in appropriations Acts for the Service (excluding funds made available for facilities, Contract Health Services, or contract support costs), the Secretary shall use such sums as are necessary to carry out this section.

“SEC. 408. Payor of last resort.

“Indian Health Programs and health care programs operated by Urban Indian Organizations shall be the
payor of last resort for services provided to persons eligible
for services from Indian Health Programs and Urban In-
dian Organizations, notwithstanding any Federal, State,
or local law to the contrary.

“SEC. 409. 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 pro-
gram 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 pro-
vider 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 Licens-
sure or Recognition Requirements.—Any re-
quirement 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 rec-
ognition, 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 Organiza-
tion, or Urban Indian Organization that has been excluded from participation in any Federal health
care program or for which a license is under suspen-
sion or has been revoked by the State where the en-
tity 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. 410. 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. 411. 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(e)(6)(B) of such Act (42 U.S.C. 1397bb(b)(3)(D), 1397ee(c)(6)(B)).
“SEC. 412. 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. 413. 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 So-
cial 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. 414. 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 Social Security Act (42 U.S.C. 1396u–2(h), 1397gg(e)(1)(H)).

“SEC. 415. 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 Security Act (relating to the State children’s health insurance program) under terms equivalent to those described in paragraphs (2) through (4).

“(c) REPORT.—Not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

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

“(2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include Navajo Lands, and other interested parties, in conducting this study;

“(3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and
“(4) legislative actions that would be required
to authorize the establishment of such entity if such
entity is determined by the Secretary to be feasible.

“SEC. 416. EXCEPTION FOR EXCEPTED BENEFITS.

“The previous provisions of this title shall not apply
to the provision of excepted benefits described in para-
graph (1)(A) or (3) of section 2791(c) of the Public
Health Service Act (42 U.S.C. 300gg–91(c)).

“SEC. 417. AUTHORIZATION OF APPROPRIATIONS.

“There are authorized to be appropriated such sums
as may be necessary 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 organiza-
tions 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 pursu-
ant 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 re-
ferral services for Urban Indians. Any such contract or
grant shall include requirements that the urban Indian or-
ganization 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 promotion and disease prevention services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under subsection (a).
“(d) Immunization Services.—

“(1) Access or Services Provided.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for Urban Indians through grants made to urban Indian organizations administering contracts entered into or receiving grants under this section.

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

“(e) 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 Indian organizations administering contracts entered into or receiving grants under subsection (a).

“(2) Assessment Required.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the following:

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

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

“(C) The barriers to obtaining those services and resources.

“(D) The needs that are unmet by such services and resources.

“(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

“(A) To prepare assessments required under paragraph (2).

“(B) To provide outreach, educational, and referral services to Urban Indians regarding the availability of direct behavioral health services, to educate Urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to Urban Indians.

“(C) To provide outpatient behavioral health services to Urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment.
“(D) To develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

“(f) PREVENTION OF CHILD ABUSE.—

“(1) ACCESS OR SERVICES PROVIDED.—The Secretary, acting through the Service, shall facilitate access to or provide services for Urban Indians through grants to urban Indian organizations administering contracts entered into or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among Urban Indians.

“(2) EVALUATION REQUIRED.—Except as provided by paragraph (3)(A), a grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

“(3) PURPOSES OF GRANTS.—Grants may be made under this subsection for the following:

“(A) To prepare assessments required under paragraph (2).
“(B) For the development of prevention, training, and education programs for Urban Indians, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection.

“(C) To provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to Urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

“(4) Considerations when making grants.—In making grants to carry out this subsection, the Secretary shall take into consideration—

“(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child

“(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. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

“(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary’s jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.
“(b) DONATIONS.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Indian Health Service or the General Services Administration for the purposes of carrying out the contract or grant.

“(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d) to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

“(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian Tribe or Tribal Organization, the Secretary shall give priority to the request for donation to the Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if earlier, the date the
Secretary transfers the property physically, to the urban Indian organization.

“(e) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C 481(a)) (relating to Federal sources of supply), an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be deemed to be an executive agency when carrying out such contract or grant.

“SEC. 505. 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 section 503.

“(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center involved and determining whether the Secretary should enter into
a contract or make a grant under section 503 with respect
to the urban Indian organization which the Secretary has
entered into a contract with, or made a grant to, under
this section.

“(c) GRANT AND CONTRACT REQUIREMENTS.—Any
contract entered into, or grant made, by the Secretary
under this section shall include requirements that—

“(1) the urban Indian organization successfully
undertakes to—

“(A) document the health care status and
unmet health care needs of urban Indians in
the Urban Center involved; and

“(B) with respect to urban Indians in the
Urban Center involved, determine the matters
described in paragraphs (2), (3), (4), and (7) of
section 503(b); and

“(2) the urban Indian organization complete
performance of the contract, or carry out the re-
quirements 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 orga-
nization receives such grant, whichever is applicable.

“(d) NO RENEWALS.—The Secretary may not renew
any contract entered into or grant made under this sec-
tion.
“SEC. 506. 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. 507. 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 re-
imbursable costs incurred by the organization
during 1 or more subsequent funding periods
without additional justification or documenta-
tion by the organization as a condition of car-
ying forward the availability for expenditure of
such funds.

“(2) SEMIANNUAL AND QUARTERLY PAYMENTS
AND REIMBURSEMENTS.—If the Secretary deter-
mines under paragraph (1)(A) that an urban Indian
organization is not capable of administering an en-
tire single advance payment, on request of the urban
Indian organization, the payments may be made—

“(A) in semianual 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 organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

“SEC. 508. REPORTS AND RECORDS.

“(a) Reports.—

“(1) In General.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into or a grant received pursuant to this title, such urban Indian organization shall submit to the Secretary not more frequently than every 6 months, a report that includes the following:

“(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 2009, 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 inde-
dependent financial audit conducted by—

“(1) a certified public accountant; or
“(2) a certified public accounting firm qualified
to conduct Federal compliance audits.

“SEC. 509. LIMITATION ON CONTRACT AUTHORITY.

“The authority of the Secretary to enter into con-
tracts or to award grants under this title shall be to the
extent, and in an amount, provided for in appropriation
Acts.

“SEC. 510. FACILITIES.

“(a) GRANTS.—The Secretary, acting through the
Service, may make grants to contractors or grant recipi-
ents under this title for the lease, purchase, renovation,
construction, or expansion of facilities, including leased fa-
cilities, in order to assist such contractors or grant recipi-
ents 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, including by submitting a report in accordance with subsection (e) of that section.

“SEC. 511. 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. 512. 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 education 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 subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

(1) The size of the urban Indian population.

(2) Capability of the organization to adequately perform the activities required under the grant.

(3) Satisfactory performance standards for the organization in meeting the goals set forth in such grant. 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. 513. 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. 514. 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, 2010, for the administration of urban Indian alcohol programs
that were originally established under the National Insti-
tute 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 re-
port to Congress on the activities of programs funded
under this section not less than every 5 years.

“SEC. 515. CONFERRING WITH URBAN INDIAN ORGANIZA-
TIONS.

“(a) IN GENERAL.—The Secretary shall ensure that
the Service confers or conferences, to the greatest extent
practicable, with Urban Indian Organizations.

“(b) DEFINITION OF CONFER; CONFERENCE.—In
this section, the terms ‘confer’ and ‘conference’ mean an
open and free exchange of information and opinions that—

“(1) leads to mutual understanding and comprehension; and

“(2) emphasizes trust, respect, and shared responsibility.

“SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

“(a) CONSTRUCTION AND OPERATION.—

“(1) IN GENERAL.—The Secretary, acting through the Service, through grant or contract, shall fund the construction and operation of at least 1 residential treatment center in each Service Area that meets the eligibility requirements set forth in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

“(2) TREATMENT.—Each residential treatment center described in paragraph (1) shall be in addition to any facilities constructed under section 707(b).

“(b) ELIGIBILITY REQUIREMENTS.—To be eligible to obtain a facility under subsection (a)(1), a Service Area shall meet the following requirements:
“(1) There is an Urban Indian Organization in the Service Area.

“(2) There reside in the Service Area Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting.

“(3) There is a significant shortage of culturally competent residential treatment services for Urban Indian youth in the Service Area.

“SEC. 517. 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. 518. 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. 519. EFFECTIVE DATE.

“The amendments made by the Indian Health Care Improvement Act Amendments of 2009 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. 520. ELIGIBILITY FOR SERVICES.

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

“SEC. 521. 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 2025 to carry out this title.

“(b) Urban Indian Organizations.—The Secretary, acting through the Service, is authorized to establish programs, including programs for the awarding of grants, for urban Indian organizations that are identical to any programs established pursuant to section 126 (behavioral health training), section 210 (school health education), section 212 (prevention of communicable diseases), section 701 (behavioral health prevention and
treatment services), and section 707(g) (multidrug abuse program).

“SEC. 522. HEALTH INFORMATION TECHNOLOGY.

“The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000(5) of the American Recovery and Reinvestment Act), telemedicine services development, and related infrastructure.

“TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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

“(a) Establishment.—

“(1) In general.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian Tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.
“(2) Assistant Secretary of Indian Health.—The Service shall be administered by an Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2010, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary 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 2009 shall serve as Assistant Secretary.

“(4) Advocacy and Consultation.—The position of Assistant Secretary is established to, in a manner consistent with the government-to-government relationship between the United States and Indian Tribes—

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

“(B) promote consultation on matters relating to Indian health.
“(b) AGENCY.—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 Assistant Secretary shall—

“(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, 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);
“(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 functions carried out under title I;

“(5) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

“(6) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

“(7) advise each Assistant Secretary of the Department concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

“(8) advise the heads of other agencies and programs of the Department concerning matters of Indian health with respect to which those heads have authority and responsibility;

“(9) coordinate the activities of the Department concerning matters of Indian health; and


“(10) perform such other functions as the Secretary may designate.

“(d) Authority.—

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

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

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

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

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

“(e) REFERENCES.—Any reference to the Director of the Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or
in any document of or relating to the Director of the Indian Health Service, shall be deemed to refer to the Assistant Secretary.

"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) privacy protections consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to privacy of automated management information systems of a Federal agency;

(D) a services-based cost accounting component that provides estimates of the costs as-
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 sys-
tems 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.—The Service shall pro-
vide access of patients to their medical or health records
which are held by, or on behalf of, the Service in accord-
ance with the regulations promulgated under section
264(c) of the Health Insurance Portability and Account-
ability Act of 1996 or, to the extent consistent with such
regulations, other Federal rules applicable to access to
health care records.
“(d) Authority To Enhance Information Technology.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.


“There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2025 to carry out this title.

“TITLE VII—BEHAVIORAL HEALTH PROGRAMS


“(a) Purposes.—The purposes of this section are as follows:

“(1) To authorize and direct the Secretary, acting through the Service, 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 In-
dian communities in areas of health care, education,
social services, child and family welfare, alcohol and
substance abuse, law enforcement, and judicial serv-
ices.

“(3) To assist Indian Tribes to identify services
and resources available to address mental illness and
dysfunctional and self-destructive behavior.

“(4) To provide authority and opportunities for
Indian Tribes and Tribal Organizations to develop,
implement, and coordinate with community-based
programs which include identification, prevention,
education, referral, and treatment services, including
through multidisciplinary resource teams.

“(5) To ensure that Indians, as citizens of the
United States and of the States in which they re-
side, have the same access to behavioral health serv-
ices to which all citizens have access.

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

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

“(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

“(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

“(ii) an estimate of the financial and human cost attributable to such illness or behavior.

“(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).
“(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to meet their responsibilities under the plans.

“(2) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall coordinate with existing national clearinghouses and information centers to include at the clearinghouses and centers plans and reports on the outcomes of such plans developed by Indian Tribes, Tribal Organizations, urban Indian organizations, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, urban Indian organization, or the Service.

“(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

“(c) PROGRAMS.—The Secretary, acting through the Service, 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 behavioral intervention;

“(B) mental health and substance abuse services (emotional, organie, alcohol, drug, inhalant, and tobacco);
“(C) identification and treatment of co-occurring disorders and comorbidity;

“(D) prevention of alcohol, drug, inhalant, and tobacco use;

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

“(F) promotion of healthy approaches to risk and safety issues; and

“(G) identification and treatment of neglect and physical, mental, and sexual abuse.

“(3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—

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

“(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including 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, 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 2009, 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 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

“(1) The scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians.

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

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

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

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

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

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

“(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (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, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including Systems of Care, 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, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

“(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian Tribes and Tribal Organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

“SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

“(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary shall establish and maintain a mental health technician program within the Service which—

“(1) provides for the training of Indians as mental health technicians; and

“(2) employs such technicians in the provision of community-based mental health care that includes
identification, prevention, education, referral, and
treatment services.

“(b) Paraprofessional Training.—In carrying
out subsection (a), the Secretary, acting through the Serv-
ice, shall provide high-standard paraprofessional training
in mental health care necessary to provide quality care to
the Indian communities to be served. Such training shall
be based upon a curriculum developed or approved by the
Secretary which combines education in the theory of men-
tal 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, shall
supervise and evaluate the mental health technicians in
the training program.

“(d) Traditional Health Care Practices.—The
Secretary, acting through the Service, shall ensure that
the program established pursuant to this subsection 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, respec-
tively.

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

“(1) works under the direct supervision of a li-
censed 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, mar-
riage and family therapy, or counseling; and

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

“SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

“(a) GRANTS.—The Secretary, consistent with sec-
tion 701, may make grants to Indian Tribes, Tribal Orga-
nizations, and urban Indian organizations to develop and
implement a comprehensive behavioral health program of
prevention, intervention, treatment, and relapse preven-
tion 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) ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.—Twenty percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.
“SEC. 707. INDIAN YOUTH PROGRAM.

“(a) DETOXIFICATION AND REHABILITATION.—The Secretary, acting through the Service, consistent with section 701, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribes or Tribal Organizations at the local level under the Indian Self-Determination and Education Assistance Act (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, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an Area Office.

“(B) AREA OFFICE IN CALIFORNIA.—For the purposes of this subsection, the Area Office in California shall be considered to be 2 Area
Offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

“(2) FUNDING.—For the purpose of staffing and operating such centers or facilities, funding shall be pursuant to the Act of November 2, 1921 (25 U.S.C. 13).

“(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

“(4) SPECIFIC PROVISION OF FUNDS.—

“(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

“(i) the Tanana Chiefs Conference,

Incorporated, for the purpose of leasing,
constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

“(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(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, may provide intermediate behavioral health services, which may incorporate Systems of Care, 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-
dian Tribe or Tribal Organization operating the pro-
gram.

“(e) REHABILITATION AND AFTERCARE SERVICES.—

“(1) IN GENERAL.—The Secretary, Indian
Tribes, or Tribal Organizations, in cooperation with
the Secretary of the Interior, shall develop and im-
plement 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, commu-
nity reintegration, and monitoring to support the In-
dian youths after their return to their home commu-
nity.

“(2) ADMINISTRATION.—Services under para-

graph (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 pro-
fessionals, and other health professionals and para-
professionals, including community health represent-
atives.

“(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, 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, 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.

“(c) 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 increase or could increase the risk of suicide.

“(2) Eligibility for Grants.—Such grants shall be awarded to Indian Tribes and Tribal 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 capabilities; 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 and Tribal 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 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 Indian youth are detained.

“(d) USE OF FUNDS.—

“(1) IN GENERAL.—An Indian Tribe or Tribal 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 re-
lated to Indian youth suicide prevention efforts.

“(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in
paragraph (1), an Indian Tribe or Tribal Organiza-
tion 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 or Tribal Organiza-
tion shall prepare and submit to the Secretary an applica-
tion, 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 or Tribal 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 and Tribal 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 and Tribal Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse 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 Affairs of the Senate and the Committee on Natural 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 attempted suicides;

“(2) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

“(3) evaluates whether the demonstration project should be—

“(A) expanded to provide more than 5 grants; and

“(B) designated a permanent program;

and

“(4) evaluates the benefits of expanding the demonstration project to include urban Indian organizations.

“(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,500,000 for each of fiscal years 2010 through 2025.

“SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

“Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, may
provide, in each area of the Service, not less than 1 inpa-
tient mental health care facility, or the equivalent, for In-
dians with behavioral health problems. For the purposes
of this subsection, California shall be considered to be 2
Area Offices, 1 office whose location shall be considered
to encompass the northern area of the State of California
and 1 office whose jurisdiction shall be considered to en-
compass the remainder of the State of California. The Sec-
retary 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 de-
velop and implement, within each Service Unit or tribal
program, a program of community education and involve-
ment 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 tradi-
tional practitioners, and other critical members of each
tribal community. Such program may also include commu-
nity-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 provide instruction in the area of behav-
ioral health issues, including instruction in crisis interven-
tion and family relations in the context of alcohol and sub-
stance abuse, child sexual abuse, youth alcohol and sub-
stance abuse, and the causes and effects of fetal alcohol
disorders to appropriate employees of the Bureau of In-
dian 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 sec-
tion 4213 of the Indian Alcohol and Substance Abuse Pre-

“(c) TRAINING MODELS.—In carrying out the edu-
cation and training programs required by this section, the
Secretary, in consultation with Indian Tribes, Tribal Or-
ganizations, Indian behavioral health experts, and Indian
alcohol and substance abuse prevention experts, shall de-
velop 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, including Systems of Care, for preventing and treating behavioral health problems.

“SEC. 711. BEHAVIORAL HEALTH PROGRAM.

“(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, 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 and acting through the Service, 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-

``(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-

``(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, shall—
``(1) develop and provide services for the pre-
vention, intervention, treatment, and aftercare for
those affected by fetal alcohol disorder in Indian communities; and

“(2) provide supportive services, 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 spectrum disorders
experts.
“(d) APPLIED RESEARCH PROJECTS.—The Sec-
retary, acting through the Substance Abuse and Mental
Health Services Administration, shall make grants to In-
dian Tribes, Tribal Organizations, and urban Indian orga-
nizations for applied research projects which propose to
elevate the understanding of methods to prevent, inter-
vene, treat, or provide rehabilitation and behavioral health
aftercare for Indians and urban Indians affected by fetal
alcohol spectrum disorders.
“(e) FUNDING FOR URBAN INDIAN ORGANIZA-
tions.—Ten percent of the funds appropriated pursuant
to this section shall be used to make grants to urban In-
dian organizations funded under title V.

“SEC. 713. CHILD SEXUAL ABUSE AND PREVENTION TREAT-
MENT PROGRAMS.
“(a) ESTABLISHMENT.—The Secretary, acting
through the Service, shall establish, consistent with section
701, in every Service Area, programs involving treatment
for—
“(1) victims of sexual abuse who are Indian children or children in an Indian household; and

“(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

“(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

“(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

“(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

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

“(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

“(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household—
“(A) making efforts to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated; and
“(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.
“(c) COORDINATION.—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

“SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.
“(a) IN GENERAL.—The Secretary, in accordance with section 701, is authorized to establish in each Service Area programs involving the prevention and treatment of—
“(1) Indian victims of domestic violence or sexual abuse; and
“(2) perpetrators of domestic violence or sexual abuse who are Indian or members of an Indian household.
“(b) USE OF FUNDS.—Funds made available to carry out this section shall be used—
“(1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

“(2) to provide behavioral health services, including victim support services, and medical treatment (including examinations performed by sexual assault nurse examiners) to Indian victims of domestic violence or sexual abuse;

“(3) to purchase rape kits;

“(4) to develop prevention and intervention models, which may incorporate traditional health care practices; and

“(5) to identify and provide behavioral health treatment to perpetrators who are Indian or members of an Indian household.

“(c) TRAINING AND CERTIFICATION.—

“(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.
“(2) REPORT.—Not later than 18 months after
the date of enactment of the Indian Health Care Im-
provement Act Amendments of 2008, the Secretary
shall submit to the Committee on Indian Affairs of
the Senate and the Committee on Natural Resources
of the House of Representatives a report that de-
scribes the means and extent to which the Secretary
has carried out paragraph (1).
“(d) COORDINATION.—
“(1) IN GENERAL.—The Secretary, in coordina-
tion with the Attorney General, Federal and tribal
law enforcement agencies, Indian Health Programs,
and domestic violence or sexual assault victim orga-
nizations, shall develop appropriate victim services
and victim advocate training programs—
“(A) to improve domestic violence or sex-
ual abuse responses;
“(B) to improve forensic examinations and
collection;
“(C) to identify problems or obstacles in
the prosecution of domestic violence or sexual
abuse; and
“(D) to meet other needs or carry out
other activities required to prevent, treat, and
improve prosecutions of domestic violence and sexual abuse.

“(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

“SEC. 715. 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. 716. 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.
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.

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 spon-
(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 Spectrum Disorders.—

(A) In General.—The term ‘fetal alcohol spectrum disorders’ includes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy, including physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

(B) Inclusions.—The term ‘fetal alcohol spectrum disorders’ may include—

(i) fetal alcohol syndrome (FAS);
(ii) fetal alcohol effect (FAE);
(iii) alcohol-related birth defects; and
(iv) alcohol-related neurodevelopmental disorders (ARND).

(6) Fetal Alcohol Syndrome or FAS.—The term ‘fetal alcohol syndrome’ or ‘FAS’ means any 1 of a spectrum of effects that may occur when
a woman drinks alcohol during pregnancy, the diagnosis of which involves the confirmed presence of the following 3 criteria:

“(A) Craniofacial abnormalities.

“(B) Growth deficits.

“(C) Central nervous system abnormalities.

“(7) REHABILITATION.—The term ‘rehabilitation’ means medical and health care services that—

“(A) are recommended by a physician or licensed practitioner of the healing arts within the scope of their practice under applicable law;

“(B) are furnished in a facility, home, or other setting in accordance with applicable standards; and

“(C) have as their purpose any of the following:

“(i) The maximum attainment of physical, mental, and developmental functioning.

“(ii) Averting deterioration in physical or mental functional status.

“(iii) The maintenance of physical or mental health functional status.

“(8) SUBSTANCE ABUSE.—The term ‘substance abuse’ includes inhalant abuse.
“(9) Systems of care.—The term ‘Systems of Care’ means a system for delivering services to children and their families that is child-centered, family-focused and family-driven, community-based, and culturally competent and responsive to the needs of the children and families being served. The systems of care approach values prevention and early identification, smooth transitions for children and families, child and family participation and advocacy, comprehensive array of services, individualized service planning, services in the least restrictive environment, and integrated services with coordinated planning across the child-serving systems.

“SEC. 717. AUTHORIZATION OF APPROPRIATIONS.

“There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2025 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 2009, 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 pro-
grams established or assisted pursuant to this Act and assessments and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians and ensure a health status for Indians, which are at a parity with the health services available to and the health status of the general population.

“(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian Tribes, Tribal Organizations, and urban Indian organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 807.

“(3) A report on the use of health services by Indians—

“(A) on a national and area or other relevant geographical basis;

“(B) by gender and age;

“(C) by source of payment and type of service;
“(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

“(E) 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(m).

“(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(e).

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

“(10) A report on environmental and nuclear health hazards as required by section 215.
“(11) An annual report on the status of all health care facilities needs as required by section 301(c)(2)(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 807.

“(22) A report on the movement of patients between Service Units, including—

“(A) a list of those Service Units that have a net increase and those that have a net decrease of patients due to patients assigned to one Service Unit voluntarily choosing to receive service at another Service Unit;

“(B) an analysis of the effect of patient movement on the quality of services for those Service Units experiencing an increase in the number of patients served; and

“(C) what funding changes are necessary to maintain a consistent quality of service at Service Units that have an increase in the number of patients served.

“(23) A report on the extent to which health care facilities of the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations comply with credentialing requirements of the Service or licensure requirements of States.
“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 2009, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act, except sections 105, 115, 117, 202, and 409 through 416. The Secretary may promulgate regulations to carry out such sections using the procedures required by chapter 5 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 2009 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 2009.

“(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.

“SEC. 803. PLAN OF IMPLEMENTATION.

“(a) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, 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.).

“(b) LACK OF PLAN.—The lack of (or failure to sub-
mit) such a plan shall not limit the effect, or prevent the
implementation, of this Act.

“SEC. 804. LIMITATION ON USE OF FUNDS APPROPRIATED
TO INDIAN HEALTH SERVICE.

“Any limitation on the use of funds contained in an
Act providing appropriations for the Department for a pe-
riod with respect to the performance of abortions shall
apply for that period with respect to the performance of
abortions using funds contained in an Act providing ap-
propriations for the Service.

“SEC. 805. ELIGIBILITY OF CALIFORNIA INDIANS.

“(a) IN GENERAL.—The following California Indians
shall be eligible for health services provided by the Service:

“(1) Any member of a federally recognized In-
dian Tribe.

“(2) Any descendant of an Indian who was re-
siding in California on June 1, 1852, if such de-
scendant—

“(A) is a member of the Indian community
served by a local program of the Service; and
“(B) is regarded as an Indian by the 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. 806. 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 area of the Service Unit and who are not otherwise eligible for such health services if—

“(A) the Indian Tribes served by such Service Unit request such provision of health services to such individuals; and

“(B) the Secretary and the served Indian Tribes have jointly determined that—

“(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

“(ii) there is no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health needs of such individuals.

“(2) ISDEAA PROGRAMS.—In the case of health programs and facilities operated under a contract 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 Indian Tribe or Tribal Organization providing health services under such contract or compact is authorized 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 provision of law. In making such determinations, the governing body of the Indian Tribe or Tribal Organization shall take into account the considerations described in 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 judgment 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 reimbursements under titles XVIII, XIX, and XXI of the Social Security Act, shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under
this subsection shall be available for 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 suc-
ceeding the fiscal year in which the governing
body of the Indian Tribe revokes its concur-
rence to the provision of such health services.

“(B) Multitribal service area.—In
the case of a multitribal Service Area, the au-
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.—

“(1) IN GENERAL.—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 Edu-
cation 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.

“(2) DEFINITION.—For purposes of this subsection, the term ‘non-Service health care practitioner’ means a practitioner who is not—

“(A) an employee of the Service; or

“(B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act or an individual who provides health care services pursuant to a personal services contract with such Indian tribe or tribal organization.
“(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. 807. TREATMENT OF CERTAIN SERVICES AND BENEFITS.

“(a) Gross income does not include (1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service; (2) health services, health benefits or other amounts for health care services, including preventive care and treatment of personal injuries or sickness and other health conditions, provided by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance); (3) the value of health coverage provided or premiums paid by an Indian tribe or tribal organization to or on behalf of an Indian under an accident or health plan (or through an arrangement having the effect of accident or health insurance); or (4) any other benefit or service provided by an Indian tribe that supplements the programs and services
provided by the Federal government to Indian tribes or Indians, or other general welfare benefits or services provided by Indian tribes to Indians.

“(b) Definitions.—For the purposes of this section:

“(1) The terms ‘accident or health insurance’ and ‘personal injuries and sickness’ have the meaning given those terms in section 104 of the Internal Revenue Code of 1986.

“(2) The term ‘Indian tribe’ has the meaning given that term in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).

“(3) The term ‘Indians’ and ‘Indian’ means any person who—

“(A) is a member of an Indian tribe, as defined in paragraph (2); and

“(B)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized by the State in which they reside;

“(ii) is a descendant, in the first or second degree, of any such member;
“(iii) is an Eskimo or Aleut or other Alaskan Native;

“(iv) is otherwise eligible for services provided or funded by the Indian Health Service under applicable law; or

“(v) is considered by the Secretary of the Interior to be an Indian for any purpose.

“(4) The term ‘tribal organization’ has the meaning given that term in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).

“(c) No Inference.—Nothing in this section is intended as an inference to the tax treatment of governmental benefits (including health care benefits not covered under this section) provided by Indian tribes to Indians after the date of the enactment 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 appro-
priated to the Service for the previous fiscal year.

“SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

“The Secretary shall provide for the dissemination to
Indian Tribes, Tribal Organizations, and urban Indian or-
ganizations 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 serv-
ices and benefits for Indians in Montana in a manner con-
sistent with the decision of the United States Court of Ap-
peals 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 Mon-
tana.
“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 Department of Health and Human Services, 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 805 and 806, until the Service has submitted to the Committees on Appropriations of the Senate and the House of Representatives a budget request reflecting the increased costs associated with the proposed final rule, and the request has been included in an appropriations Act and enacted into law.

“SEC. 812. 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. 813. USE OF PATIENT SAFETY ORGANIZATIONS.

“The Service, an Indian Tribe, Tribal Organization, or urban Indian organization may provide for quality as-
surance activities through the use of a patient safety orga-
nization in accordance with title IX of the Public Health
Service Act.

"SEC. 814. CONFIDENTIALITY OF MEDICAL QUALITY ASSUR-
ANCE RECORDS; QUALIFIED IMMUNITY FOR
PARTICIPANTS.

"(a) CONFIDENTIALITY OF RECORDS.—Medical qual-
ity assurance records created by or for any Indian Health
Program or a health program of an Urban Indian Organi-
zation as part of a medical quality assurance program are
central and privileged. Such records may not be dis-
closed to any person or entity, except as provided in sub-
section (c).

"(b) PROHIBITION ON DISCLOSURE AND TESTI-
MONY.—

"(1) IN GENERAL.—No part of any medical
quality assurance record described in subsection (a)
may be subject to discovery or admitted into evi-
dence in any judicial or administrative proceeding,
except as provided in subsection (c).

"(2) TESTIMONY.—A person who reviews or
creates medical quality assurance records for any In-
dian Health Program or Urban Indian Organization
who participates in any proceeding that reviews or
creates such records may not be permitted or re-
required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

"(c) AUTHORIZED DISCLOSURE AND TESTIMONY.—

"(1) IN GENERAL.—Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person referred to in subsection (b) may give testimony in connection with such a record, only as follows:

"(A) To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian Health Program or to a health program of an Urban Indian Organization to perform monitoring, required by law, of such program or organization.

"(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization provider concerning the termination, sus-
pension, or limitation of clinical privileges of
such health care provider.

“(C) To a governmental board or agency
or to a professional health care society or orga-
nization, if such medical quality assurance
record or testimony is needed by such board,
agency, society, or organization to perform li-
censing, credentialing, or the monitoring of pro-
fessional standards with respect to any health
care provider who is or was an employee of any
Indian Health Program or Urban Indian Orga-
nization.

“(D) To a hospital, medical center, or
other institution that provides health care serv-
ices, if such medical quality assurance record or
testimony is needed by such institution to as-
sess the professional qualifications of any health
care provider who is or was an employee of any
Indian Health Program or Urban Indian Orga-
nization and who has applied for or been grant-
ed authority or employment to provide health
care services in or on behalf of such program or
organization.

“(E) To an officer, employee, or contractor
of the Indian Health Program or Urban Indian
Organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

“(F) To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

“(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality referred to in subparagraph (F), but only with respect to the subject of such proceeding.

“(2) IDENTITY OF PARTICIPANTS.—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian Health Program or Urban Indian Organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (a) shall be deleted
from that record or document before any disclosure
of such record is made outside such program or or-
ganization.
“(d) Disclosure for Certain Purposes.—
“(1) In General.—Nothing in this section
shall be construed as authorizing or requiring the
withholding from any person or entity aggregate sta-
tistical information regarding the results of any In-
dian Health Program or Urban Indian
Organizations’s medical quality assurance programs.
“(2) Withholding from Congress.—Noth-
ing in this section shall be construed as authority to
withhold any medical quality assurance record from
a committee of either House of Congress, any joint
committee of Congress, or the Government Account-
ability Office if such record pertains to any matter
within their respective jurisdictions.
“(e) Prohibition on Disclosure of Record or
Testimony.—A person or entity having possession of or
access to a record or testimony described by this section
may not disclose the contents of such record or testimony
in any manner or for any purpose except as provided in
this section.
“(f) Exemption from Freedom of Information
Act.—Medical quality assurance records described in sub-
section (a) may not be made available to any person under
section 552 of title 5, United States Code.

“(g) LIMITATION ON CIVIL LIABILITY.—A person
who participates in or provides information to a person
or body that reviews or creates medical quality assurance
records described in subsection (a) shall not be civilly lia-
ble for such participation or for providing such informa-
tion if the participation or provision of information was
in good faith based on prevailing professional standards
at the time the medical quality assurance program activity
took place.

“(h) APPLICATION TO INFORMATION IN CERTAIN
OTHER RECORDS.—Nothing in this section shall be con-
strued as limiting access to the information in a record
created and maintained outside a medical quality assur-
ance program, including a patient’s medical records, on
the grounds that the information was presented during
meetings of a review body that are part of a medical qual-
ity assurance program.

“(i) REGULATIONS.—The Secretary, acting through
the Service, shall promulgate regulations pursuant to sec-
tion 802.

“(j) DEFINITIONS.—In this section:

“(1) The term ‘health care provider’ means any
health care professional, including community health
aides and practitioners certified under section 121, who are granted clinical practice privileges or employed to provide health care services in an Indian Health Program or health program of an Urban Indian Organization, who is licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

“(2) The term ‘medical quality assurance program’ means any activity carried out before, on, or after the date of enactment of this Act by or for any Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Program or Urban Indian Organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

“(3) The term ‘medical quality assurance record’ means the proceedings, records, minutes, and
reports that emanate from quality assurance pro-
gram activities described in paragraph (2) and are
produced or compiled by or for an Indian Health
Program or Urban Indian Organization as part of a
medical quality assurance program.

“(k) CONTINUED PROTECTION.—Disclosure under
subsection (c) does not permit redisclosure except to the
extent such further disclosure is authorized under sub-
section (e) or is otherwise authorized to be disclosed under
this section.

“(l) INCONSISTENCIES.—To the extent that the pro-
tections under the Patient Safety and Quality Improve-
ment Act of 2005 and this section are inconsistent, the
provisions of whichever is more protective shall control.

“(m) RELATIONSHIP TO OTHER LAW.—This section
shall continue in force and effect, except as otherwise spe-
cifically provided in any Federal law enacted after the date
of enactment of the Indian Health Care Improvement Act
Amendments of 2009.

“SEC. 815. CLAREMORE INDIAN HOSPITAL.

“The Claremore Indian Hospital shall be deemed to
be a dependant Indian community for the purposes of sec-
tion 1151 of title 18, United States Code.
“SEC. 816. SENSE OF CONGRESS REGARDING LAW ENFORCEMENT AND METHAMPHETAMINE ISSUES IN INDIAN COUNTRY.

“It is the sense of Congress that Congress encourages State, local, and Indian tribal law enforcement agencies to enter into memoranda of agreement between and among those agencies for purposes of streamlining law enforcement activities and maximizing the use of limited resources—

“(1) to improve law enforcement services provided to Indian tribal communities; and

“(2) to increase the effectiveness of measures to address problems relating to methamphetamine use in Indian country (as defined in section 1151 of title 18, United States Code).

“SEC. 817. PERMITTING IMPLEMENTATION THROUGH CONTRACTS WITH TRIBAL HEALTH PROGRAMS.

“Nothing in this Act shall be construed as preventing the Secretary from—

“(1) carrying out any section of this Act through contracts with Tribal Health Programs; and

“(2) carrying out sections through 214, 701(a)(1), 701(b)(1), 701(c), 707(g), and 712(b), through contracts with urban Indian organizations.
The previous sentence shall not affect the authority the Secretary may otherwise have to carry out other provisions of this Act through such contracts.

SEC. 818. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.

(a) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

(b) Limitation on New Spending Authority.—Any new spending authority (described in subparagraph (A) or (B) of section 401(c)(2) of the Congressional Budget Act of 1974 (Public Law 93–344; 88 Stat. 317)) 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.

(c) Availability.—The funds appropriated pursuant to this Act shall remain available until expended.”.

(b) Rate of Pay.—

(1) Positions at Level IV.—Section 5315 of title 5, United States Code, is amended by striking “Assistant Secretaries of Health and Human Services (6).” and inserting “Assistant Secretaries of Health and Human Services (7)”.

(2) Positions at Level V.—Section 5316 of title 5, United States Code, is amended by striking
“Director, Indian Health Service, Department of Health and Human Services”.

(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—

(1) Section 3307(b)(1)(C) of the Children’s Health Act of 2000 (25 U.S.C. 1671 note; Public Law 106–310) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—

(A) in section 3 (25 U.S.C. 3902)—

(i) by striking paragraph (2);

(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and

(iii) by inserting before paragraph (4) (as redesignated by subclause (II)) the following:

“(3) ASSISTANT SECRETARY.—The term ‘Assistant Secretary’ means the Assistant Secretary for Indian Health.”;
(B) in section 5 (25 U.S.C. 3904), by striking the section designation and heading and inserting the following:

“SEC. 5. AUTHORITY OF ASSISTANT SECRETARY FOR INDIAN HEALTH.”;

(C) in section 6(a) (25 U.S.C. 3905(a)), in the subsection heading, by striking “DIRECTOR” and inserting “ASSISTANT SECRETARY”;

(D) in section 9(a) (25 U.S.C. 3908(a)), in the subsection heading, by striking “DIRECTOR” and inserting “ASSISTANT SECRETARY”;

and

(E) by striking “Director” each place it appears and inserting “Assistant Secretary”.

(3) Section 5504(d)(2) of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (25 U.S.C. 2001 note; Public Law 100–297) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(4) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

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(5) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377) are amended by striking “Director of the Indian Health Service” each place it appears and inserting “Assistant Secretary for Indian Health”.

(6) Section 317M(b) of the Public Health Service Act (42 U.S.C. 247b–14(b)) is amended—

(A) by striking “Director of the Indian Health Service” each place it appears and inserting “Assistant Secretary for Indian Health”; and

(B) in paragraph (2)(A), by striking “the Directors referred to in such paragraph” and inserting “the Director of the Centers for Disease Control and Prevention and the Assistant Secretary for Indian Health”.

(7) Section 417C(b) of the Public Health Service Act (42 U.S.C. 285–9(b)) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(8) Section 1452(i) of the Safe Drinking Water Act (42 U.S.C. 300j–12(i)) is amended by striking “Director of the Indian Health Service” each place it appears and inserting “Assistant Secretary for Indian Health”.

(9) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)) is amended in the last sentence by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(10) Section 203(b) of the Michigan Indian Land Claims Settlement Act (Public Law 105–143; 111 Stat. 2666) is amended by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

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 pur-
poses of determining Federal appropriations re-
lating to the provision of health care and serv-
ices 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 feder-
ally 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 activities 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 individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

“(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—

“(1) IN GENERAL.—The Secretary shall establish 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 necessary 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-
m

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”.

SEC. 104. GAO STUDY AND REPORT ON PAYMENTS FOR

CONTRACT HEALTH SERVICES.

(a) Study.—

(1) IN GENERAL.—The Comptroller General of
the United States (in this section referred to as the
“Comptroller General”) shall conduct a study on the
utilization of health care furnished by health care
providers under the contract health services program
funded by the Indian Health Service and operated
by the Indian Health Service, an Indian Tribe, or a
Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

(2) Analysis.—The study conducted under paragraph (1) shall include an analysis of—

(A) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for such health care through other public programs and in the private sector;

(B) barriers to accessing care under such contract health services program, including, but not limited to, barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under such program;

(C) the adequacy of existing Federal funding for health care under such contract health services program; and

(D) any other items determined appropriate by the Comptroller General.

(b) Report.—Not later than 18 months after the date of enactment of this Act, the Comptroller General
shall submit to Congress a report on the study conducted under subsection (a), together with recommendations regard-
ing—

(1) the appropriate level of Federal funding that should be established for health care under the contract health services program described in subsection (a)(1); and

(2) how to most efficiently utilize such funding.

(e) CONSULTATION.—In conducting the study under subsection (a) and preparing the report under subsection (b), the Comptroller General shall consult with the Indian Health Service, Indian Tribes, and Tribal Organizations.

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.

(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.—An Indian Health Program 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 Program 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) REPEAL OF OBSOLETE PROVISION.—Subsection (b) of such section is repealed.

(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 Organiza-
tion (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. This subsection shall not be construed to impair the entitlement of a State to reimbursement for such medical assistance under this title.”.

(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:

“(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, see subparagraphs (A) and (B) of section 401(c)(1) of such Act.

“(d) DIRECT BILLING.—For provisions relating to the authority of an Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment
is made under this title, see section 401(d) of the Indian Health Care Improvement Act.”.

(5) DEFINITIONS.—Section 1101(a) of such Act (42 U.S.C. 1301(a)) is amended by adding at the end the following new paragraph:

“(11) For purposes of this title and titles XVIII, XIX, and XXI, the terms ‘Indian Health Program’, ‘Indian Tribe’ (and ‘Indian tribe’), ‘Tribal Health Program’, ‘Tribal Organization’ (and ‘tribal organization’), and ‘urban Indian 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), an Indian Health Program shall be eligible for
payments under this title with respect to items and services furnished by the Program 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) **Repeal of Obsolete Provision.**—Subsection (b) of such section is repealed.

(3) **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 (c), 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.”.

(4) 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:

“(b) 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 sub-paragraphs (A) and (B) of section 401(c)(1) of such Act.

“(c) Direct billing.—For provisions relating to the authority of a Tribal Health Program to elect to directly bill for, and receive payment for, health care items and services provided by such Program for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.”.
(B) CONFORMING AMENDMENTS.—Such section is further amended—

(i) in subsection (e)(3), by striking “Subsection (c)” and inserting “Subsection (b) and section 401(b)(1) of the Indian Health Care Improvement Act”;

(ii) by redesignating subsection (e) as subsection (d); and

(iii) by striking subsection (f).

(5) 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 (c) 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, acting through the Centers for Medicare & Medicaid Services, shall encourage each State with all or part of a reservation within its borders to take steps to provide for
enrollment on or near such reservations. 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 paragraph (1) 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) FACILITATING COOPERATION IN ENROLLMENT AND RETENTION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall consult with States, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to develop and disseminate best practices with respect to facilitating agreements between the States and Indian Tribes, Tribal Organizations, and urban Indian organizations relating to enrollment and retention of Indians in programs established under titles XVIII, XIX, and 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 OUT-REACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID.

(a) 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”.

(b) 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”.

(c) DEFINITIONS.—Section 2110(c) of such Act (42 U.S.C. 1397jjj(c)) is amended by adding at the end the following new paragraph:

“(9) INDIAN; INDIAN HEALTH PROGRAM; INDIAN TRIBE; ETC.—The terms ‘Indian’, ‘Indian Health Program’, ‘Indian Tribe’, ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.”

SEC. 204. 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 redesignating 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 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.

“(B) 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 Indian Health 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 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-
er the entity meets such standards, if the pro-
fessional is licensed in another State.

“(2) Prohibition on Federal Payments to
Entities or Individuals Excluded from Par-
ticipation in Federal Health Care Programs
Or Whose State Licenses Are Under Suspen-
sion or Have Been Revoked.—

“(A) Excluded Entities.—No entity op-
erated by the Indian Health Service, an Indian
Tribe, Tribal Organization, or Urban Indian
Organization that has been excluded from par-
ticipation 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 serv-
ices 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 receive payment for health care services, to an Indian.

“(C) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, ‘Federal health care program’ has the meaning given that term in section 1128B(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.”.

SEC. 205. SOLICITATION OF PROPOSALS FOR SAFE HARBORS UNDER THE SOCIAL SECURITY ACT FOR FACILITIES OF INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.

The Secretary of Health and Human Services, acting through the Office of the Inspector General of the Department of Health and Human Services, shall publish a no-
practice, described in section 1128D(a)(1)(A) of the Social Security Act (42 U.S.C. 1320a–7d(a)(1)(A)), soliciting a proposal, not later than July 1, 2010, on the development of safe harbors described in such section relating to health care items and services provided by facilities of Indian Health Programs or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act). Such a safe harbor may relate to areas such as transportation, housing, or cost-sharing, assistance provided through such facilities or contract health services for Indians.

SEC. 206. 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.”.

SEC. 207. DEVELOPMENT OF RECOMMENDATIONS TO IMPROVE INTERSTATE COORDINATION OF MEDICAID AND SCHIP COVERAGE OF INDIAN CHILDREN AND OTHER CHILDREN WHO ARE OUTSIDE OF THEIR STATE OF RESIDENCY BECAUSE OF EDUCATIONAL OR OTHER NEEDS.

(a) STUDY.—The Secretary shall conduct a study to identify barriers to interstate coordination of enrollment and coverage under the Medicaid program under title XIX of the Social Security Act and the State Children’s Health Insurance Program under title XXI of such Act of children who are eligible for medical assistance or child health assistance under such programs and who, because of educational needs, migration of families, emergency evacuations, or otherwise, frequently change their State of residency or otherwise are temporarily present outside of the State of their residency. Such study shall include an examination of the enrollment and coverage coordination issues faced by Indian children who are eligible for medical as-
sistance or child health assistance under such programs in their State of residence and who temporarily reside in an out-of-State boarding school or peripheral dormitory funded by the Bureau of Indian Affairs.

(b) Report.—Not later than 18 months after the date of enactment of this Act, the Secretary, in consultation with directors of State Medicaid programs under title XIX of the Social Security Act and directors of State Children’s Health Insurance Programs under title XXI of such Act, shall submit a report to Congress that contains recommendations for such legislative and administrative actions as the Secretary determines appropriate to address the enrollment and coverage coordination barriers identified through the study required under subsection (a).