S. HRG. 106–491, PT. 4

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

S. 2526

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

AUGUST 4, 2000
BISMARCK, ND

PART 4

U.S. GOVERNMENT PRINTING OFFICE

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APPENDIX

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

FRIDAY, AUGUST 4, 2000

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Bismarck, ND

The committee met, pursuant to notice, at 9:30 a.m. at the James Henry Community Center, United Tribes Technical College, Bismarck, North Dakota, Hon. Byron L. Dorgan (acting chairman of the committee) presiding.

Present: Senators Dorgan and Conrad.

STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, ACTING CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator DORGAN. Ladies and gentlemen, good morning to all of you. Thank you for being here. My name is Byron Dorgan. I'm a U.S. Senator representing North Dakota. I'm joined by my colleague, Senator Kent Conrad, and we are both members of the Committee on Indian Affairs in the United States Senate.

This hearing today is authorized by the chairman of the Indian Affairs Committee at the request of Senator Conrad and myself. We are joined today by a staff member representing Ben Nighthorse Campbell, the Senator from Colorado and the chairman of the Indian Affairs Committee, Aurene Martin, who is sitting behind me. Aurene, thank you for being here, and Stephanie Mohl on my staff, who also works on issues before the Indian Affairs Committee is with us right behind me on my left.

This hearing is the fourth and final hearing that will be held on the bill S. 2526 to reauthorize the Indian Health Care Improvement Act. Senator Conrad and I asked that we hold a hearing in North Dakota. Senator Campbell had hoped to be able to be here today but he was not able to be here. However, he did ask that Senator Conrad and I proceed to hold the hearing because he, too, wanted to have a fourth hearing—a field hearing—on this bill. So all of the statements we are about to hear will be part of the permanent record. We are having a transcript made of this hearing, and this will be an official hearing of the Senate Committee on Indian Affairs.

[Text of S. 2526 follows:]

II

106TH CONGRESS
2D SESSION

S. 2526

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

IN THE SENATE OF THE UNITED STATES

MAY 9, 2000

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

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A BILL

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

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 Reauthorization of 2000".

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

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

SEC. 101. AMENDMENT TO THE INDIAN HEALTH CARE IMPROVEMENT ACT.

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. 2. FINDINGS.

"Congress makes the following findings:

"(1) Federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the

of dealings of the United States with Indian Tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

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

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

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

"(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than that of the general population, and to provide for the

maximum participation of Indian Tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

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

"(7) Despite such services, the unmet health needs of the American Indian people remain alarmingly severe, and even continue to increase, and the health status of the Indians is far below the health status of the general population of the United States.

"(8) The disparity in health status that is to be addresses is formidable. In death rates for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher than the death rate for all races in the United States, a pneumonia and influenza death rate that is 71 percent higher, a tuberculosis death rate that is 533 percent higher, and a death rate from alcoholism that is 627 percent higher.

"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people—

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

"(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto;

"(3) in order to raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto, to permit Indian Tribes and tribal organizations 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 geographic service area is raised to at least the level of that of the general population;

"(5) to require meaningful, active consultation with Indian Tribes, Indian organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

"(6) that funds for health care programs and facilities operated by Tribes and tribal organizations be provided in amounts that are not less than the funds that are provided to programs and facilities operated directly by the Service.

"SEC. 4. DEFINITIONS.

"In this Act:

"(1) ACCREDITED AND ACCESSIBLE.—The term 'accredited and accessible', with respect to an entity, means a community college or other appropriate entity that is on or near a reservation and accredited by a national or regional organization with accrediting authority.

"(2) AREA OFFICE.—The term 'area office' mean an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary of the Indian Health as established under section 601.

"(4) CONTRACT HEALTH SERVICE.—The term 'contract health service' means a health service that is provided at the expense of the Service, Indian Tribe, or tribal organization by a public or private medical provider or hospital, other than a service funded under the Indian Self-Determination and Education Assistance Act or under this Act.

"(5) DEPARTMENT.—The term 'Department', unless specifically provided otherwise, means the Department of Health and Human Services.

"(6) FUND.—The terms 'fund' or 'funding' mean the transfer of monies from the Department to any eligible entity or individual under this Act by any legal means, including funding agreements, contracts, memoranda of understanding, Buy Indian Act contracts, or otherwise.

"(7) FUNDING AGREEMENT.—The term 'funding agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, functions, services and activities to Tribes and tribal organizations from the Secretary under the authority of the Indian Self-Determination and Education Assistance Act.

"(8) HEALTH PROFESSION.—The term 'health profession' means allopathic medicine, family medi-

cine, 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, and allied health professions, or any other health profession.

"(9) HEALTH PROMOTION; DISEASE PREVENTION.—The terms 'health promotion' and 'disease prevention' shall have the meanings given such terms in paragraphs (1) and (2) of section 203(c).

"(10) INDIAN.—The term 'Indian' and 'Indians' shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.

"(11) INDIAN HEALTH PROGRAM.—The term 'Indian health program' shall have the meaning given such term in section 110(a)(2)(A).

"(12) INDIAN TRIBE.—The term 'Indian tribe' shall have the meaning given such term in section 4(e) of the Indian Self Determination and Education Assistance Act.

"(13) RESERVATION.—The term 'reservation' means any Federally recognized Indian tribe's res-

ervation, Pueblo or colony, including former reservations in Oklahoma, Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act, and Indian allotments.

"(14) SECRETARY.—The term 'Secretary', unless specifically provided otherwise, means the Secretary of Health and Human Services.

"(15) SERVICE.—The term 'Service' means the Indian Health Service.

"(16) SERVICE AREA.—The term 'service area' means the geographical area served by each area office.

"(17) SERVICE UNIT.—The term 'service unit' means—

"(A) an administrative entity within the Indian Health Service; or

"(B) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

"(18) TRADITIONAL HEALTH CARE PRACTICES.—The term 'traditional health care practices'

means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to western healing sciences) which embodies the influences or forces of innate tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which calls upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation and maintenance of health, well-being, and life's harmony.

"(19) TRIBAL ORGANIZATION.—The term 'tribal organization' shall have the meaning given such term in section 4(l) of the Indian Self Determination and Education Assistance Act.

"(20) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' shall have the meaning given such term in section 126 (g)(2).

"(21) URBAN CENTER.—The term 'urban center' means any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

"(22) URBAN INDIAN.—The term 'urban Indian' means any individual who resides in an urban center and who—

"(A) regardless of whether such 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;

"(B) is an Eskimo or Aleut or other Alaskan 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.

"(23) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the participation of all interested Indian groups and individuals, and which 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 Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health services to Indian people.

"SEC. 102. GENERAL REQUIREMENTS.

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

"(1) to be developed in consultation with Indian Tribes, tribal organizations and urban Indian organizations; and

"(2) that takes into account the human resource and development needs in each such service area.

"(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously con-

sult with representatives of Indian tribes, tribal organizations, and urban Indian organizations to prioritize the utilization of funds provided under this title within the service area.

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

"(d) LIMITATION.—This section shall not apply with respect to individual recipients of scholarships, loans or other funds provided under this title (as this title existed 1 day prior to the date of enactment of this Act) until such time as the individual completes the course of study that is supported through the use of such funds.

"SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall make funds available through the area office to public or nonprofit private health entities, or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

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

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

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

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

"(3) establishing other programs which the area office 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) ADMINISTRATIVE PROVISIONS.—

"(1) APPLICATION.—To be eligible to receive funds under this section an entity described in subsection (a) shall submit to the Secretary, through the appropriate area office, and have approved, an application in such form, submitted in such manner, and containing such information as the Secretary shall by regulation prescribe.

"(2) PREFERENCE.—In awarding funds under this section, the area office shall give a preference to applications submitted by Indian tribes, tribal organizations, or urban Indian organizations.

"(3) AMOUNT.—The amount of funds to be provided to an eligible entity under this section shall be determined by the area office. Payments under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations promulgated pursuant to this Act.

"(4) TERMS.—A funding commitment under this section shall, to the extent not otherwise prohibited by law, be for a term of 3 years, as provided for in regulations promulgated pursuant to this Act.

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

"(1) irrespective of whether such 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;

"(2) is an Eskimo or Aleut or other Alaska Native;

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

"(4) is determined to be an Indian under regulations promulgated by the Secretary.

"SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

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

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

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

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

"(1) Compensatory preprofessional education of any recipient. Such scholarship shall not exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated 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 (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act) except that an extension of up to 2 years may be approved by the Secretary.

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

"(d) LIMITATIONS.—Scholarship assistance to an eligible applicant under this section shall not be denied solely on the basis of—

"(1) the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; or

"(2) the applicant's eligibility for assistance or benefits under any other Federal program.

"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

"(a) SCHOLARSHIPS.—

"(1) IN GENERAL.—In order to meet the needs of Indians, Indian tribes, tribal organizations, and urban Indian organizations for health professionals, the Secretary, acting through the Service and in ac-

cordance with this section, shall provide scholarships through the area offices to Indians who are enrolled full or part time in accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall, except as provided in subsection (b), be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l).

"(2) NO DELEGATION.—The Director of the Service shall administer this section and shall not delegate any administrative functions under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act.

"(b) ELIGIBILITY.—

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

"(2) SERVICE OBLIGATION.—

"(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under

that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year for year obligation, by service—

"(i) in the Indian Health Service;

"(ii) in a program conducted under a funding agreement entered into under the Indian Self-Determination and Education Assistance Act;

"(iii) in a program assisted under title V; or

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

"(B) DEFERRING ACTIVE SERVICE.—At the request of any Indian who has entered into a contract referred to in subparagraph (A) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary

shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

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

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

"(iii) The active duty service obligation will be served in the health profession of that individual, in a manner consistent with clauses (i) through (iv) of subparagraph (A).

"(C) NEW SCHOLARSHIP RECIPIENTS.—A recipient of an Indian Health Scholarship that

is awarded after December 31, 2001, shall meet the active duty service obligation under such scholarship by providing service within the service area from which the scholarship was awarded. In placing the recipient for active duty the area office shall give priority to the program that funded the recipient, except that in cases of special circumstances, a recipient may be placed in a different service area pursuant to an agreement between the areas or programs involved.

"(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

"(3) PART-TIME ENROLLMENT.—In the case of an Indian receiving a scholarship under this section

who is enrolled part time in an approved course of study—

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

"(B) the period of obligated service described in paragraph (2)(A) shall be equal to the greater of—

"(i) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the area office); or

"(ii) two years; and

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

"(4) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with

the area office pursuant to a scholarship under this section and who—

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

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

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

"(iv) 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, shall be liable to the United States for the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A) an individual breaches his or her written contract by failing either to begin such individual's service obligation under this section or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(C) DEATH.—Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

"(D) WAIVER.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the appropriate area office, Indian tribe, tribal organization, and urban Indian organization, determines that—

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

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

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

"(E) HARDSHIP OR GOOD CAUSE.—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.

"(F) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under 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.

"(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.—

"(1) PROVISION OF FUNDS.—

"(A) IN GENERAL.—The Secretary shall make funds available, through area offices, to Indian Tribes and tribal organizations for the purpose of assisting such Tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

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

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

"(2) REQUIREMENTS.—

"(A) IN GENERAL.—An Indian Tribe or tribal organization receiving funds under paragraph (1) shall agree to provide scholarships to

Indians in accordance with the requirements of this subsection.

"(B) MATCHING REQUIREMENT.—With respect to the costs of providing any scholarship pursuant to subparagraph (A)—

"(i) 80 percent of the costs of the scholarship shall be paid from the funds provided under paragraph (1) to the Indian Tribe or tribal organization; and

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

"(3) ELIGIBILITY.—An Indian Tribe or tribal organization shall provide scholarships under this subsection only to Indians who are enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in this Act.

"(4) CONTRACTS.—In providing scholarships under paragraph (1), the Secretary and the Indian Tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

"(A) obligate such recipient to provide service in an Indian health program (as defined in section 110(a)(2)(A)) in the same service

area where the Indian Tribe or tribal organization providing the scholarship is located, for—

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

"(ii) such greater period of time as the recipient and the Indian Tribe or tribal organization may agree;

"(B) provide that 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), such amount to be reduced pro rata (as determined by the

Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance 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 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 the health profession involved.

"(5) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An individual who has entered into a written contract with the Sec-

retary and an Indian Tribe or tribal organization under this subsection and who—

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

"(ii) is dismissed from such education for disciplinary reasons;

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

"(iv) 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;

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.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A), an individual breaches his or her written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(C) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Indian Tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary deems appropriate.

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

"(A) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made

pursuant to the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

"(B) 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 of such Act to provide service to individuals entitled to medical assistance under the plan.

"(7) PAYMENTS.—The Secretary, through the area office, shall make payments under this subsection to an Indian Tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary or area office determines that, for the immediately preceding fiscal year, the Indian Tribe or tribal organization has not complied with the requirements of this subsection.

"SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

"(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds to at least 3 colleges and

universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various colleges and universities throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

"(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.—The Secretary shall provide funds 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 American Indians Into Nursing Program authorized under section 115, the Quentin N. Burdick Indians into Health Program authorized under section 117, and existing university research and communications networks.

"(c) REQUIREMENTS.—

"(1) REGULATIONS.—The Secretary shall promulgate regulations pursuant to this Act for the competitive awarding of funds under this section.

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

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

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

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

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

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

"(F) utilizes, to the maximum extent feasible, existing university tutoring, counseling and student support services; and

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

"(d) ACTIVE DUTY 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 graduate who receives a stipend described in subsection (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

"(1) in the Indian Health Service;

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

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

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

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to

employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship.

"(b) ENROLLEES IN COURSE OF STUDY.—Any individual who is enrolled in a course of study in the health professions may be employed by the Service or by an Indian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(c) HIGH SCHOOL PROGRAMS.—Any individual who is in a high school program authorized under section 103(a) may be employed by the Service, or by a Indian Tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(d) ADMINISTRATIVE PROVISIONS.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency per-

sonnel 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 health professionals, including for purposes of this section, community health representatives and emergency medical technicians, to join or continue in the Service or in any program of an Indian tribe, tribal organization, or urban Indian organization and to provide their services in the rural and remote areas where a significant portion of the Indian people reside, the Secretary, acting through the area offices, may provide allowances to health professionals employed in the Service or such a program to enable such professionals to take leave of their duty stations for a period of time each year (as prescribed by regulations of the Secretary) for professional consultation and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall maintain a Community Health Representative Program under which the Service, Indian tribes and tribal organizations—

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

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

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Representative Program, 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 such 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

"(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 maintain programs that meet the needs for such continuing education;

"(4) maintain a system that provides close supervision of community health representatives;

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

"(6) promote traditional health care practices of the Indian tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

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

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall establish a program to be

known as the Indian Health Service Loan Repayment Program (referred to in this Act as the 'Loan Repayment Program') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

"(2) DEFINITIONS.—In this section:

"(A) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

"(i) directly by the Service;

"(ii) by any Indian tribe or tribal or Indian organization pursuant to a funding agreement under—

"(I) the Indian Self-Determination and Educational Assistance Act; or

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

"(iii) by an urban Indian organization pursuant to title V.

"(B) STATE.—The term 'State' has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.

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

"(1)(A) be enrolled—

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

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

"(B) have—

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

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

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

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

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

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

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

"(c) FORMS.—

"(1) IN GENERAL.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Indian Health

Service to enable the individual to make a decision on an informed basis.

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

"(d) PRIORITY.—

"(1) ANNUAL DETERMINATIONS.—The Secretary, acting through the Service and in accordance with subsection (k), shall annually—

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

"(B) rank those positions in order of priority.

"(2) PRIORITY IN APPROVAL.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall give priority to applications made by—

"(A) Indians; and

"(B) individuals recruited through the efforts an Indian tribe, tribal organization, or urban Indian organization.

"(e) CONTRACTS.—

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

"(2) NOTICE.—Not later than 21 days after considering an individual for participation in the Loan Repayment Program under paragraph (1), the Secretary shall provide written notice to the individual of—

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

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

"(f) WRITTEN CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

"(1) an agreement under which—

"(A) subject to paragraph (3), 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 tribe, tribal organization, or urban Indian organization as provided in subparagraph (B)(iii); and

"(B) subject to paragraph (3), 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)—

"(I) 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

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

"(iii) to serve for a time period (referred to in this section as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary;

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

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

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

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

"(g) LOAN REPAYMENTS.—

"(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 OF PAYMENT.—

"(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) 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) 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—

"(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

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

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program 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.

"(B) TIME FOR PAYMENT.—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 not later than the end of the fiscal year in which the individual completes such year of service.

"(3) SCHEDULE FOR PAYMENTS.—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) COUNTING OF INDIVIDUALS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be

counted against any employment ceiling affecting the Department.

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

"(j) NONAPPLICATION OF CERTAIN PROVISION.—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 pursuant to contracts entered into under this section, shall—

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

"(2) give priority to assigning individuals to Indian health programs 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) IN GENERAL.—An individual who has entered into a written contract with the Secretary under this section and who—

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

"(i) fails to maintain an acceptable level of academic standing in the educational institution in which he 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 who fails to complete such training program, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii),

shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.

"(2) AMOUNT OF RECOVERY.—If, for any reason not specified in paragraph (1), an individual breaches his written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (f), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula:

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

in which—

"(A) 'A' is the amount the United States is entitled to recover;

"(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

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

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

Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

"(3) DAMAGES.—

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

"(B) DELINQUENCIES.—If damages described in subparagraph (A) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

"(i) utilize collection agencies contracted with by the Administrator of the General Services Administration; or

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

"(C) CONTRACTS FOR RECOVERY OF DAMAGES.—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) CANCELLATION, WAIVER OR RELEASE.—

"(1) CANCELLATION.—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.

"(2) WAIVER OF SERVICE OBLIGATION.—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.

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

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

"(1) the health professional positions maintained by the Service or by tribal or 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 (f) 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 scholarship grants that are provided under section 105 with respect to each health profession;

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

"(7) the number of providers of health care that will be needed by Indian health programs, by location and profession, during the 3 fiscal years beginning after the date the report is filed; and

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

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

"(a) ESTABLISHMENT.—Notwithstanding section 102, 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 (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

"(1) such amounts as may be collected from individuals under subparagraphs (A) and (B) of section 105(b)(4) and section 110(l) for breach of contract;

"(2) such funds as may be appropriated to the LRRF;

"(3) such interest earned on amounts in the LRRF; and

"(4) such additional amounts as may be collected, appropriated, or earned relative to the LRRF.

Amounts appropriated to the LRRF shall remain available until expended.

"(b) USE OF LRRF.—

"(1) IN GENERAL.—Amounts in the LRRF may be expended by the Secretary, subject to section 102, acting through the Service, to make payments to the Service or to an Indian tribe or tribal organization administering a health care program pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act—

"(A) to which a scholarship recipient under section 105 or a loan repayment program participant under section 110 has been assigned to

meet the obligated service requirements pursuant to 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 105 or section 110.

"(2) SCHOLARSHIPS AND RECRUITING.—An Indian tribe or tribal organization receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or to recruit and employ, directly or by contract, health professionals to provide health care services.

"(c) INVESTING OF FUND.—

"(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary 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.

"(2) SALE PRICE.—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 OF EXPENSES.—The Secretary may reimburse health professionals seeking positions in the Service, Indian tribes, tribal organizations, or urban Indian organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

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

"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

"(a) FUNDING OF PROJECTS.—The Secretary, acting through the Service, shall fund innovative projects for a period not to exceed 3 years to enable Indian tribes, tribal organizations, and urban Indian organizations to recruit, place, and retain health professionals to meet the staffing

needs of Indian health programs (as defined in section 110(a)(2)(A)).

"(b) ELIGIBILITY.—Any Indian tribe, tribal organization, 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 PROJECT.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian health program (as defined in section 110) for a substantial period of time to pursue advanced training or research in areas of study for which the Secretary determines a need exists.

"(b) SERVICE OBLIGATION.—

"(1) IN GENERAL.—An individual who participates in the project under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to at least the period of time during which the individual participates in such project.

"(2) FAILURE TO COMPLETE SERVICE.—In the event that an individual fails to complete a period of obligated service under paragraph (1), the individual shall be liable to the United States for the period of

service remaining. In such event, with respect to individuals entering the project after the date of the enactment of this Act, 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) OPPORTUNITY TO PARTICIPATE.—Health professionals from Indian tribes, tribal organizations, and urban Indian organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to participate in the program under subsection (a).

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

"(a) GRANTS.—Notwithstanding section 102, the Secretary, acting through the Service, shall provide funds to—

"(1) public or private schools of nursing;

"(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) nurse midwife programs, and advance practice nurse programs, that are provided by any tribal college accredited nursing program, or in the absence of such, any other public or private institution,

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

"(b) USE OF GRANTS.—Funds provided under subsection (a) may be used to—

"(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses;

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

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

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

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

"(c) APPLICATIONS.—Each application for funds 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.—In providing funds under subsection (a), the Secretary shall extend a preference to—

"(1) programs that provide a preference to Indians;

"(2) programs that train nurse midwives or advanced practice nurses;

"(3) programs that are interdisciplinary; and

"(4) programs that are conducted in cooperation with a center for gifted and talented Indian students established under section 5324(a) of the Indian Education Act of 1988.

"(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available 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 American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

"(f) 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 under subsection (a). Such obligation shall be met by service—

"(1) in the Indian Health Service;

"(2) in a program conducted under a contract entered into under the Indian Self-Determination and Education assistance Act;

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

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

"SEC. 116. TRIBAL CULTURE AND HISTORY.

"(a) IN GENERAL.—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 tribes and their relationship to the Service.

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

"(1) be provided in consultation with the affected tribal governments, tribal organizations, and urban Indian organizations;

"(2) be provided through tribally-controlled community colleges (within the meaning of section 2(4) of the Tribally Controlled Community College Assistance Act of 1978) and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) include instruction in Native American studies.

"SEC. 117. INMED PROGRAM.

"(a) GRANTS.—The Secretary may provide grants to 3 colleges and universities for the purpose of maintaining

ment program known as the 'Indians into Medicine Program' (referred to in this section as 'INMED') as a means of encouraging Indians to enter the health professions.

"(b) QUENTIN N. BURDICK INDIAN HEALTH PROGRAM.—The Secretary shall provide 1 of the grants under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

"(c) REQUIREMENTS.—

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

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

"(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community

colleges located on Indian reservations which will be served by the program;

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

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

"(D) provides tutoring, counseling and support to students who are enrolled in a health career program of study at the respective college or university; and

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

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

"(a) ESTABLISHMENT GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health pro-

fession for individuals who desire to practice such profession on an Indian reservation, in the Service, or in a tribal health program.

"(2) AMOUNT.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $100,000.

"(b) CONTINUATION GRANTS.—

"(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) ELIGIBILITY.—Grants may only be made under this subsection to a community college that—

"(A) is accredited;

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

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

"(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

"(ii) stipulate certifications necessary to approve internship and field placement opportunities at health programs of the Service or at tribal 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) SERVICE PERSONNEL AND 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) SPECIFIED COURSES OF STUDY.—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—

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

"(2) provides clinical services on an Indian reservation, at a Service facility, or at a tribal clinic.

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

"(f) DEFINITIONS.—In this section:

"(1) COMMUNITY COLLEGE.—The term 'community college' means—

"(A) a tribally controlled community college; or

"(B) a junior or community college.

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

"(3) TRIBALLY CONTROLLED COLLEGE.—The term 'tribally controlled college' has the meaning given the term 'tribally controlled community college' by section 2(4) of the Tribally Controlled Community College Assistance Act of 1978.

"SEC. 119. RETENTION BONUS.

"(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an 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 the Service, tribe, tribal organization, or urban organization;

"(3) has—

"(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban 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 the Service, Indian tribe, tribal organization, 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) FAILURE TO COMPLETE TERM OF SERVICE.—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

determined by the Secretary in accordance with section 110(l)(2)(B).

"(d) FUNDING AGREEMENT.—The Secretary may pay a retention bonus to any health professional employed by an organization providing health care services to Indians pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act if such health professional is serving in a position which the Secretary determines is—

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

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

"SEC. 120. NURSING RESIDENCY PROGRAM.

"(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 110(a)(2)(A)), and have done so for a period of not less than 1 year, to pursue advanced training.

"(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) leading to an associate

or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse) or an advanced degrees in nursing and public health.

"(c) 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 for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.

"(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 maintain a Community Health Aide Program in Alaska under which the Service—

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

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

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

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

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

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

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

"(B) provides instruction and practical experience in the provision of acute care, emer-

gency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

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

"(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 who can demonstrate equivalent experience;

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

"(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

"(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the pro-

vision of quality health care, health promotion, and disease prevention services.

"SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

"Subject to Section 102, the Secretary, acting through the Service, shall, through a funding agreement or otherwise, provide training for Indians in the administration and planning of tribal health programs.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROJECT.

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

"(b) PURPOSE.—It is the purpose of the health professions demonstration project under this section to—

"(1) provide direct clinical and practical experience in a service area to health professions students and residents from medical schools;

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

"(3) provide academic and scholarly opportunities for health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

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

"SEC. 124. SCHOLARSHIPS.

"Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'qualified scholarships' for purposes of section 117 of the Internal Revenue Code of 1986.

"SEC. 125. NATIONAL HEALTH SERVICE CORPS.

"(a) LIMITATIONS.—The Secretary shall not—

"(1) remove a member of the National Health Services Corps from a health program operated by Indian Health Service or by a tribe or tribal organization under a funding agreement with the Service under the Indian Self-Determination and Education Assistance Act, or by urban Indian organizations; or

"(2) withdraw the funding used to support such a member;

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

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

"(c) FULL TIME EQUIVALENT.—National Health Service Corps scholars that qualify for the commissioned corps in the Public Health Service shall be exempt from the full time equivalent limitations of the National Health Service Corps and the Service when such scholars serve as commissioned corps officers in a health program operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization.

"SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT.

"(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible commu-

nity colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

"(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

"(c) TERM OF GRANT.—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1 year period upon the approval of the Secretary.

"(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, 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 projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

"(e) TECHNICAL 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.—The Secretary shall submit to the President, for inclusion in the report required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.

"(g) DEFINITIONS.—In this section:

"(1) EDUCATIONAL CURRICULUM.—The term 'educational curriculum' means 1 or more of the following:

"(A) Classroom education.

"(B) Clinical work experience.

"(C) Continuing education workshops.

"(2) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' has the meaning given such term in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

"(3) TRIBALLY CONTROLLED POSTSECONDARY VOCATIONAL INSTITUTION.—The term 'tribally controlled postsecondary vocational institution' has the meaning given such term in section 390(2) of the

Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)).

"SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION.

"(a) STUDY AND LIST.—

"(1) IN GENERAL.—The Secretary 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, dysfunctional or self-destructive behavior.

"(2) POSITIONS.—The positions referred to in paragraph (1) are—

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

"(i) elementary and secondary education;

"(ii) social services, family and child welfare;

"(iii) law enforcement and judicial services; and

"(iv) alcohol and substance abuse;

"(B) staff positions within the Service; and

"(C) staff positions similar to those specified in subsection (b) and established and maintained by Indian tribes, tribal organizations, and urban Indian organizations, including positions established pursuant to funding agreements under the Indian Self-determination and Education Assistance Act, and this Act.

"(3) TRAINING CRITERIA.—

"(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position specified in subsection (b)(1) and ensure that appropriate training has been or will be provided to any individual in any such position.

"(B) TRAINING.—With respect to any such individual in a position specified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training or provide funds to an Indian tribe, tribal organization, or urban Indian organization for the training of appropriate individuals. In the case of a funding agreement, the appropriate Secretary shall

ensure that such training costs are included in the funding agreement, if necessary.

"(4) CULTURAL RELEVANCY.—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.

"(5) COMMUNITY EDUCATION.—

"(A) DEVELOPMENT.—The Service shall develop and implement, or on request of an Indian tribe or tribal organization, assist an Indian tribe or tribal organization, in developing and implementing a program of community education on mental illness.

"(B) TECHNICAL ASSISTANCE.—In carrying out this paragraph, the Service shall, upon the request of an Indian tribe or tribal organization, provide technical assistance to the Indian tribe or tribal organization to obtain and develop community educational materials on the identification, prevention, referral and treatment of mental illness, dysfunctional and self-destructive behavior.

"(b) STAFFING.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of the Act, the Director of the Service shall develop a plan under which the Service will increase the number of health care staff that are providing mental health services by at least 500 positions within 5 years after such date of enactment, with at least 200 of such positions devoted to child, adolescent, and family services. The allocation of such positions shall be subject to the provisions of section 102(a).

"(2) IMPLEMENTATION.—The plan developed under paragraph (1) shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly know as the 'Snyder Act').

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

"(a) IN GENERAL.—The Secretary may expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, that are appropriated under the authority of this section, for the purposes of—

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

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

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

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

"(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status 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) accident prevention programs;

"(H) home health care;

"(I) community health representatives;

"(J) maintenance and repair; and

"(K) traditional health care practices.

"(b) USE OF FUNDS.—

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

"(2) ALLOCATION.—

"(A) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to service units or Indian tribes or tribal organizations. The funds allocated to each tribe, tribal organization, or service unit under this

subparagraph shall be used to improve the health status and reduce the resource deficiency of each tribe served by such service unit, tribe or tribal organization.

"(B) APPORTIONMENT.—The apportionment of funds allocated to a service unit, tribe or tribal organization under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes in accordance with this section and such rules as may be established under title VIII.

"(c) HEALTH STATUS AND RESOURCE DEFICIENCY.—In this section:

"(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

"(A) the health status objective set forth in section 3(2) is 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) RESOURCES.—The health resources available to an Indian tribe or tribal organization shall 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) REVIEW OF DETERMINATION.—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 tribe or tribal organization.

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

"(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit to the Congress the current health sta-

tus and resource deficiency report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged 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 resource deficiency of each Indian tribe served by the Service;

"(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service; and

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service, for the preceding fiscal year which is allocated to each service unit, Indian tribe, or comparable entity;

"(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 or Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

"(f) BUDGETARY RULE.—Funds appropriated under the authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs or to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

"(h) DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

"SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby established an Indian Catastrophic Health Emergency Fund (referred to in this section as the 'CHEF') consisting of—

"(A) the amounts deposited under subsection (d); and

"(B) any amounts appropriated to the CHEF under this Act.

"(2) ADMINISTRATION.—The CHEF shall be administered by the Secretary solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

"(3) EQUITABLE ALLOCATION.—The CHEF shall be equitably allocated, apportioned or delegated on a service unit or area office basis, based upon a formula to be developed by the Secretary in consultation with the Indian tribes and tribal organizations through negotiated rulemaking under title VIII. Such formula shall take into account the added needs of service areas which are contract health service dependent.

"(4) NOT SUBJECT TO CONTRACT OR GRANT.—No part of the CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

"(5) ADMINISTRATION.—Amounts provided from the CHEF shall be administered by the area offices based upon priorities determined by the Indian tribes and tribal organizations within each service area, including a consideration of the needs of Indian tribes and tribal organizations which are contract health service-dependent.

"(b) REQUIREMENTS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section—

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

"(2) provide that a service unit, Indian tribe, or tribal organization shall not be eligible for reimbursement for the cost of treatment from the CHEF until its cost of treatment for any victim of such a catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

"(A) for 1999, not less than $19,000; and

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

"(3) establish a procedure for the reimbursement of the portion of the costs incurred by—

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

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

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

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

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

source of reimbursement for which the patient is eligible.

"(c) LIMITATION.—Amounts appropriated to the CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act) or any other law.

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

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

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

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

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

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and through Indian tribes and tribal organizations, shall provide health promotion and

disease prevention services to Indians so as to achieve the health status objective set forth in section 3(b).

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

"(1) DISEASE PREVENTION.—The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications, and the reduction in the consequences of such diseases, including—

"(A) controlling—

"(i) 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) for the fluoridation of water; and

"(ii) immunizations.

"(2) HEALTH PROMOTION.—The term 'health promotion' means fostering social, economic, envi-

ronmental, and personal factors conducive to health, including—

"(A) raising people's awareness about health matters and enabling them 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;

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

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

"(G) promoting adequate opportunity for spiritual, religious, and traditional practices; and

"(H) adequate and appropriate programs including—

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

"(iii) community health;

"(iv) community safety;

"(v) consumer health education;

"(vi) diet and nutrition;

"(vii) disease prevention (communicable, immunizations, HIV/AIDS);

"(viii) environmental health;

"(ix) exercise and physical fitness;

"(x) fetal alcohol disorders;

"(xi) first aid and CPR education;

"(xii) human growth and development;

"(xiii) injury prevention and personal safety;

"(xiv) mental health (emotional, self-worth);

"(xv) personal health and wellness practices;

"(xvi) personal capacity building;

"(xvii) prenatal, pregnancy, and infant care;

"(xviii) psychological well being;

"(xix) reproductive health (family planning);

"(xx) safe and adequate water;

"(xxi) safe housing;

"(xxii) safe work environments;

"(xxiii) stress control;

"(xxiv) substance abuse;

"(xxv) sanitary facilities;

"(xxvi) tobacco use cessation and reduction;

"(xxvii) violence prevention; and

"(xxviii) such other activities identified by the Service, an Indian tribe or tribal organization, to promote the achievement of the objective described in section 3(b).

"(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement 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 to meet such needs; and

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

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

"(a) DETERMINATION.—The Secretary, in consultation with Indian tribes and tribal organizations, shall determine—

"(1) by tribe, tribal organization, and service unit of the Service, the prevalence of, and the types of complications resulting from, diabetes among Indians; and

"(2) based on paragraph (1), the measures (including patient education) each service unit should take to reduce the prevalence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that service unit.

"(b) SCREENING.—The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by an Indian tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act.

"(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2012, each effective model diabetes project in existence on the date of the en-

erated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.

"(d) DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian tribes and tribal organizations to establish dialysis programs, including funds to purchase dialysis equipment and provide necessary staffing.

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

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

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

"(3) ensure that data collected in each area office regarding diabetes and related complications

among Indians is disseminated to tribes, tribal organizations, and all other area offices.

"SEC. 205. SHARED SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into funding agreements or other arrangements with Indian tribes or tribal organizations for the delivery of long-term care and similar services to Indians. Such projects shall provide for the sharing of staff or other services between a Service or tribal facility and a long-term care or other similar facility owned and operated (directly or through a funding agreement) by such Indian tribe or tribal organization.

"(b) REQUIREMENTS.—A funding agreement or other arrangement entered into pursuant to subsection (a)—

"(1) may, at the request of the Indian tribe or tribal organization, delegate to such 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 facility be allocated propor-

tionately between the Service and the tribe or tribal organization; and

"(3) may authorize such tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

"(c) 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.

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

"SEC. 206. HEALTH SERVICES RESEARCH.

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

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

"(c) ELIGIBILITY FOR FUNDS.—Indian tribes and tribal organizations receiving funding from the Service under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

"(d) USE.—Funds received under this section may be used for both clinical and non-clinical research by Indian tribes and tribal organizations and shall be distributed to the area offices. Such area offices may make grants using such funds within each area.

"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

"The Secretary, through the Service or through Indian tribes or tribal organizations, shall provide for the following screening:

"(1) Mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act.

"(2) Other cancer screening meeting national standards.

"SEC. 208. PATIENT TRAVEL COSTS.

"The Secretary, acting through the Service, Indian tribes and tribal organizations shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving health care services provided (either through direct or contract care or through funding agreements entered into pursuant to the Indian Self-Determination and Education Assistance Act) under this Act:

"(1) Emergency air transportation and non-emergency air transportation where ground transportation is infeasible.

"(2) Transportation by private vehicle, specially equipped vehicle and ambulance.

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

"SEC. 209. EPIDEMIOLOGY CENTERS.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this Act, (including those centers for which funding is currently being provided through funding agree-

ments under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in paragraph (2). Any centers established under the preceding sentence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

"(2) FUNCTIONS.—In consultation with and upon the request of Indian tribes, tribal organizations and urban Indian organizations, each area epidemiology center established under this subsection shall, with respect to such area shall—

"(A) collect data related to the health status objective described in section 3(b), and monitor the progress that the Service, Indian tribes, tribal organizations, and urban Indian organizations have made in meeting such health status objective;

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

"(C) 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;

"(D) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities;

"(E) make recommendations to improve health care delivery systems for Indians and urban Indians;

"(F) provide requested technical assistance to Indian Tribes and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

"(G) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian organizations to promote public health.

"(3) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall

provide technical assistance to the centers in carrying out the requirements of this subsection.

"(b) FUNDING.—The Secretary may make funding available to Indian tribes, tribal organizations, and eligible intertribal consortia or urban Indian organizations to conduct epidemiological studies of Indian communities.

"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide funding to Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and urban Indian children.

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

"(1) develop and implement health education curricula both for regular school programs and after school programs;

"(2) train teachers in comprehensive school health education curricula;

"(3) integrate school-based, community-based, and other public and private health promotion efforts;

"(4) encourage healthy, tobacco-free school environments;

"(5) coordinate school-based health programs with existing services and programs available in the community;

"(6) develop school programs on nutrition education, personal health, oral health, and fitness;

"(7) develop mental health wellness programs;

"(8) develop chronic disease prevention programs;

"(9) develop substance abuse prevention programs;

"(10) develop injury prevention and safety education programs;

"(11) develop activities for the prevention and control of communicable diseases;

"(12) develop community and environmental health education programs that include traditional health care practitioners;

"(13) carry out violence prevention activities; and

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

"(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian tribes,

tribal organization and urban Indian organizations in the development of comprehensive health education plans, and the dissemination of comprehensive health education materials and information on existing health programs and resources.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes tribal organizations, and urban Indian organizations shall establish criteria for the review and approval of applications for funding under this section.

"(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

"(1) DEVELOPMENT.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary and affected Indian tribes and tribal organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 for use in schools operated by the Bureau of Indian Affairs.

"(2) REQUIREMENTS.—The program developed under paragraph (1) shall include—

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

"(B) mental health wellness programs;

"(C) chronic disease prevention programs;

"(D) substance abuse prevention programs;

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

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

"(3) TRAINING AND COORDINATION.—The Secretary of the Interior shall—

"(A) provide training to teachers in comprehensive school health education curricula;

"(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

"(C) encourage healthy, tobacco-free school environments.

"SEC. 211. INDIAN YOUTH PROGRAM.

"(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to provide funding to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—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) LIMITATION.—Funds made available under this section may not be used to provide services described in section 707(c).

"(c) REQUIREMENTS.—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.—The Secretary, in consultation with Indian tribes, tribal organization, and urban Indian organizations, shall establish criteria for the review and approval of applications under this section.

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

"(a) IN GENERAL.—The Secretary, acting through the Service after consultation with Indian tribes, tribal organizations, urban Indian organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian tribes and tribal organizations for—

"(1) projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori;

"(2) public information and education programs for the prevention, control, and elimination of communicable and infectious diseases; and

"(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.

"(b) REQUIREMENT OF APPLICATION.—The Secretary may provide funds under subsection (a) only if an application or proposal for such funds is submitted.

"(c) TECHNICAL ASSISTANCE AND REPORT.—In carrying out this section, the Secretary—

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

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

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

"(a) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objective set forth in section 3 through health care related services and programs not otherwise described in this Act. Such services and programs shall include services and programs related to—

"(1) hospice care and assisted living;

"(2) long-term health care;

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

"(4) public health functions; and

"(5) traditional health care practices.

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

"(c) DEFINITIONS.—In this section:

"(1) HOME- AND COMMUNITY-BASED SERVICES.—The term 'home- and community-based services' means 1 or more of the following:

"(A) Homemaker/home health aide services.

"(B) Chore services.

"(C) Personal care services.

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

"(E) Training for family members.

"(F) Adult day care.

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

"(2) HOSPICE CARE.—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 such care.

"(3) PUBLIC HEALTH FUNCTIONS.—The term 'public health functions' means public health related programs, functions, and services including assessments, assurances, and policy development that Indian tribes and tribal organizations are authorized and encouraged, in those circumstances where it meets their needs, to carry out by forming collaborative relationships with all levels of local, State, and Federal governments.

"SEC. 214. INDIAN WOMEN'S HEALTH CARE.

"The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs adminis-

tered by the Service, in order to improve and enhance the treatment models of care for Indian women.

"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

"(a) STUDY AND MONITORING PROGRAMS.—The Secretary and the Service shall, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and tribal organizations, conduct a study and carry out ongoing monitoring programs to determine the trends that exist in the health hazards posed to Indian miners and to Indians on or near Indian reservations and in Indian communities as a result of environmental hazards that may result in chronic or life-threatening health problems. Such hazards include nuclear resource development, petroleum contamination, and contamination of the water source or of the food chain. Such study (and any reports with respect to such study) shall include—

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

"(2) an analysis of the potential effect of ongoing and future environmental resource development on or near Indian reservations and communities in-

cluding the cumulative effect of such development over time on health;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal, oil and gas production or transportation on or near Indian reservations or communities, and other development that could affect the health of Indians and their water supply and food chain;

"(4) a summary of any findings or recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of this Act that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

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

"(b) DEVELOPMENT OF HEALTH CARE PLANS.—Upon the completion of the study under subsection (a), the Secretary and the Service shall take into account the results of such study and, in consultation with Indian tribes and tribal organizations, develop a health care plan to address the health problems that were the subject of such study. 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 TO CONGRESS.—

"(1) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Service shall submit to Congress

a report concerning the study conducted under subsection (a).

"(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan 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 the health problems involved.

"(d) TASK FORCE.—

"(1) ESTABLISHED.—There is hereby established an Intergovernmental Task Force (referred to in this section as the 'task force') that shall be composed of the following individuals (or their designees):

"(A) The Secretary of Energy.

"(B) The Administrator 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.

"(2) DUTIES.—The Task Force shall 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 an Indian reservation or in an Indian community, and 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) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

"(e) PROVISION OF APPROPRIATE MEDICAL CARE.—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 a Service facility; and

"(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine

or mill operator or entity responsible for the environmental hazard;

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

"SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2012, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a con-

tract health service delivery area pursuant to subsection (a).

"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM.

"(a) IN GENERAL.—The Secretary may fund a program that utilizes the California Rural Indian Health Board as a contract care intermediary to improve the accessibility of health services to California Indians.

"(b) REIMBURSEMENT OF BOARD.—

"(1) AGREEMENT.—The Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred pursuant to this section in providing medical treatment under contract to California Indians described in section 809(b) throughout the California contract health services delivery area described in section 218 with respect to high-cost contract care cases.

"(2) ADMINISTRATION.—Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be used for reimbursement for administrative expenses incurred by the Board during such fiscal year.

"(3) LIMITATION.—No payment may be made for treatment provided under this section to the ex-

tent that payment may be made for such treatment under the 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.

"(c) ADVISORY BOARD.—There is hereby established an advisory board that shall advise the California Rural Indian Health Board in carrying out this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under this section, at least 50 percent of whom are not affiliated with the California Rural Indian Health Board.

"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 Indians in such State, except that any of the counties described in this section may 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) IN GENERAL.—The Secretary, acting through the Service, shall 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) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

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

"The Service shall provide funds for health care programs and facilities operated by Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act on the same basis as such funds

are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

"Health care professionals employed by Indian Tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

"SEC. 222. AUTHORIZATION FOR 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) REQUIREMENT.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

"(b) FAILURE TO RESPOND.—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) PAYMENT.—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 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.

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

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE III—FACILITIES

"SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

"(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), 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, that such facility meets the construction standards of any nationally recognized accrediting body by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURE OF FACILITIES.—

"(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by

the Service, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such proposed closure an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

"(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

"(B) the cost effectiveness of such closure;

"(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

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

"(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

"(F) the level of utilization of such hospital or facility by all eligible Indians; and

"(G) the distance between such hospital or facility and the nearest operating Service hospital.

"(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility

or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

"(c) PRIORITY SYSTEM.—

"(1) ESTABLISHMENT.—The Secretary shall establish a health care facility priority system, that shall—

"(A) be developed with Indian tribes and tribal organizations through negotiated rulemaking under section 802;

"(B) give the needs of Indian tribes' the highest priority; and

"(C) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E);

except that the priority of any project established under the construction priority system in effect on the date of this Act shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as one of the top 10 priority inpatient projects or one of the top 10 outpatient projects in the Indian Health Service budget justification for fiscal year 2000, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of this Act.

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

"(A) a description of the health care facility priority system of the Service, as established under paragraph (1);

"(B) health care facility lists, including—

"(i) the total health care facility planning, design, construction and renovation needs for Indians;

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

"(iii) the 10 top-priority outpatient care facilities;

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

"(v) any staff quarters associated with such prioritized facilities;

"(C) the justification for the order of priority among facilities;

"(D) the projected cost of the projects involved; and

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

"(3) CONSULTATION.—In preparing each report required under paragraph (2) (other than the initial report) the Secretary shall annually—

"(A) consult with, and obtain information on all health care facilities needs from, Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act; and

"(B) review the total unmet needs of all tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

"(4) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluat-

ing the needs of facilities operated directly by the Service.

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

"(d) REVIEW OF NEED FOR FACILITIES.—

"(1) REPORT.—Beginning in 2001, the Secretary shall annually submit to the President, for inclusion in the report required to be transmitted to Congress under section 801 of this Act, a report which sets forth the needs of the Service and all Indian tribes and tribal organizations, including urban Indian organizations, for inpatient, outpatient and specialized care facilities, including the needs for renovation and expansion of existing facilities .

"(2) CONSULTATION.—In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into

with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

"(3) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

"(4) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of facilities operated under funding agreements, in accordance with the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the development of the health facility priority system.–

"(5) ANNUAL NOMINATIONS.—Each year the Secretary shall provide an opportunity for the nomination of planning, design, and construction projects by the Service and all Indian tribes and tribal organizations for consideration under the health care facility priority system.

"(e) INCLUSION OF CERTAIN PROGRAMS.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act.

"(f) 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. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

"(a) FINDINGS.—Congress finds and declares that—

"(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal 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 such 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 such facilities and other preventive health measures;

"(4) many Indian homes and communities still lack safe water supply facilities and sanitary sewage and solid waste disposal facilities; and

"(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 safe and adequate water supply facilities and sanitary sewage waste disposal facilities as soon as possible.

"(b) PROVISION OF FACILITIES AND SERVICES.—

"(1) IN GENERAL.—In furtherance of the findings and declarations 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).

"(2) ASSISTANCE.—The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

"(A) 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 Indian sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the tribe or tribal organization;

"(B) ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and

"(C) priority funding for the operation, and maintenance assistance for, and emergency repairs to, tribal sanitation facilities 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.

"(3) PROVISIONS RELATING TO FUNDING.—Notwithstanding any other provision of law—

"(A) the Secretary of Housing and Urban Development is authorized to transfer funds ap-

propriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

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

"(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services 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;

"(D) the Secretary of Health and Human Services is authorized to accept all Federal funds that are available for the purpose of providing sanitation facilities and related services and place those funds into funding agreements, authorized under the Indian Self-Determination and Education Assistance Act, between the Sec-

retary and Indian tribes and tribal organizations;

"(E) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to fund up to 100 percent of the amount of a tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

"(F) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

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

"(H) the Secretary of Health and Human Services shall enter into inter-agency agree-

ments with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the Department of Agriculture, the Environmental Protection Agency and other appropriate Federal agencies, for the purpose of providing financial assistance for safe water supply and sanitary sewage disposal facilities under this Act; and

"(I) the Secretary of Health and Human Services shall, by regulation developed through rulemaking under section 802, establish standards applicable to the planning, design and construction of water supply and sanitary sewage and solid waste disposal facilities funded under this Act.

"(c) 10-YEAR FUNDING PLAN.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, shall develop and implement a 10-year funding plan to provide safe water supply and sanitary sewage and solid waste disposal facilities serving existing Indian homes and communities, and to new and renovated Indian homes.

"(d) CAPABILITY OF TRIBE OR COMMUNITY.—The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation fa-

cility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

"(e) FINANCIAL ASSISTANCE.—The Secretary may provide financial assistance to Indian tribes, tribal organizations and communities for the operation, management, and maintenance of their sanitation facilities.

"(f) RESPONSIBILITY FOR FEES FOR OPERATION AND MAINTENANCE.—The Indian family, community or tribe involved shall have the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities. If a community facility is threatened with imminent failure and there is a lack of tribal capacity to maintain the integrity or the health benefit of the facility, the Secretary may assist the Tribe in the resolution of the problem on a short term basis through cooperation with the emergency coordinator or by providing operation and maintenance service.

"(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANIZATIONS.—Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

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

"(2) any funds appropriated for the purpose of providing water supply, sewage disposal, or solid waste facilities;

on an equal basis with programs that are administered directly by the Service.

"(h) REPORT.—

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

"(A) the current Indian sanitation facility priority system of the Service;

"(B) the methodology for determining sanitation deficiencies;

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

"(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian tribes and communities to a level I sanitation deficiency as described in paragraph (4)(A).

"(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall

consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any funding agreements entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe and in developing the criteria on which the needs will be evaluated through a process of negotiated rulemaking.

"(3) 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 communities.

"(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual or community sanitation facility serving Indian homes are as follows:

"(A) A level I deficiency is a sanitation facility serving and individual or community—

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

"(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs.

"(B) A level II deficiency is a sanitation facility serving and individual or community—

"(i) which substantially or recently complied with all applicable water supply, pollution control and solid waste laws, in which the deficiencies relate to small or minor capital improvements needed to bring the facility back into compliance;

"(ii) in which the deficiencies relate to capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

"(iii) in which the deficiencies relate to the lack of equipment or training by an Indian Tribe or community to properly operate and maintain the sanitation facilities.

"(C) A level III deficiency is an individual or community facility with water or sewer service in the home, piped services or a haul system with holding tanks and interior plumbing, or where major significant interruptions to water

supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies. There is no access to or no approved or permitted solid waste facility available.

"(D) A level IV deficiency is an individual or community facility where there are no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure or where only a washeteria or central facility exists.

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

"(i) DEFINITIONS.—In this section:

"(1) FACILITY.—The terms 'facility' or 'facilities' shall have the same meaning as the terms 'system' or 'systems' unless the context requires otherwise.

"(2) 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.

"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), 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 safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, 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 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;

"(6) other necessary components of contract performance.

"(b) EXEMPTION FROM DAVIS-BACON.—For the purpose of implementing the provisions of this title, construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are exempt from the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act). For all health facilities, staff quarters and sanitation facilities, construction and renovation subcontractors shall be paid wages at rates that are not less than the prevailing wage rates for similar construction in the locality involved, as determined by the Indian tribe, Tribes, or tribal organizations served by such facilities.

"SEC. 304. SOBOBA SANITATION FACILITIES.

"Nothing in the Act of December 17, 1970 (84 Stat. 1465) shall be construed to 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. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

"(a) PERMISSIBILITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to accept any major expansion, renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act, including—

"(A) any plans or designs for such expansion, renovation or modernization; and

"(B) any expansion, renovation or modernization for which funds appropriated under any Federal law were lawfully expended;

but only if the requirements of subsection (b) are met.

"(2) PRIORITY LIST.—The Secretary shall maintain a separate priority list to address the need for increased operating expenses, personnel or equipment for such facilities described in paragraph (1). The methodology for establishing priorities shall be developed by negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian tribes and tribal organizations.

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

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

"(1) the tribe or tribal organization—

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

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

"(2) the expansion renovation or modernization—

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

"(B) is administered by the Indian tribe or tribal organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

"(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FACILITY TO BE USED AS A SERVICE FACILITY.—If any Service facility which has been expanded, renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation or modernization.

"SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

"(a) AVAILABILITY OF FUNDING.—

"(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to tribes and tribal organizations for the construction, expansion, or modernization of facili-

ties for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided for in subsections (b)(2) and (c)(1)(C)). Funding 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) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian tribe or tribal organization) pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—Funds provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

"(A) located apart from a hospital;

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

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

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

"(ii) provide annually not less than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B); and

"(iii) provide ambulatory care in a service area (specified in the funding agreement entered into under the Indian Self-Determination and Education Assistance Act) with a population of not less than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B).

"(2) LIMITATION.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion or modernization project that benefits the service population described in clauses (ii) and (iii) of paragraph (1)(C). The requirements of such clauses (ii) and (iii) shall

not apply to a tribe or tribal organization applying for funding under this section whose principal office for health care administration is located on an island or where such office is not located on a road system providing direct access to an inpatient hospital where care is available to the service population.

"(c) APPLICATION AND PRIORITY.—

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

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

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

"(C) such facility will, as feasible without diminishing the quality or quantity of services

provided to eligible Indians, serve noneligible persons on a cost basis.

"(2) PRIORITY.—In awarding funds under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

"A) a need for increased ambulatory care services; and

"(B) insufficient capacity to deliver such services.

"(d) FAILURE TO USE FACILITY AS HEALTH FACILITY.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized 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) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Edu-

cation Assistance Act or for reallocation or redesign thereunder.

"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

"(a) HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, may enter into funding agreements with, or make grants or loan guarantees to, Indian tribes or tribal organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through health facilities, including hospice, traditional Indian health and child care facilities, to Indians.

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

"(1) waive any leasing prohibition;

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

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

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

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

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

"(c) CRITERIA.—

"(1) IN GENERAL.—The Secretary shall develop and publish regulations through rulemaking under section 802 for the review and approval of applications submitted under this section. The Secretary may enter into a contract, funding agreement or award a grant under this section for projects which meet the following criteria:

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

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

"(C) The project has the potential to address the health needs of Indians in an innovative manner.

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

"(E) The project is economically viable.

"(F) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

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

"(2) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such applications using the criteria developed pursuant to paragraph (1).

"(3) PRIORITY.—The Secretary shall give priority to applications for demonstration projects under this section in each of the following service units to the extent that such applications are filed in a timely manner and otherwise meet the criteria specified in paragraph (1):

"(A) Cass Lake, Minnesota.

"(B) Clinton, Oklahoma.

"(C) Harlem, Montana.

"(D) Mescalero, New Mexico.

"(E) Owyhee, Nevada.

"(F) Parker, Arizona.

"(G) Schurz, Nevada.

"(H) Winnebago, Nebraska.

"(I) Ft. Yuma, California

"(d) 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.

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

"(f) EQUITABLE TREATMENT.—For purposes of subsection (c)(1)(A), the Secretary shall, in evaluating facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

"(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation and expansion needs of Service and

non-Service facilities which are the subject of a funding agreement for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

"SEC. 308. LAND TRANSFER.

"(a) GENERAL AUTHORITY FOR TRANSFERS.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

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

"SEC. 309. LEASES.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized, in carrying out

the purposes of this Act, to enter into leases with Indian tribes and tribal organizations for periods not in excess of 20 years. Property leased by the Secretary from an Indian tribe or tribal organization may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe or tribal organization.

"(b) FACILITIES FOR THE ADMINISTRATION AND DELIVERY OF HEALTH SERVICES.—The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

"(1) title to;

"(2) a leasehold interest in; or

"(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and

maintenance expenses, and other expenses determined by regulation to be allowable pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

"SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAYMENT.

"(a) HEALTH CARE FACILITIES LOAN FUND.—There is established in the Treasury of the United States a fund to be known as the 'Health Care Facilities Loan Fund' (referred to in this Act as the 'HCFLF') to provide to Indian Tribes and tribal organizations direct loans, or guarantees for loans, for the construction of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities such as behavioral health and elder care facilities).

"(b) STANDARDS AND PROCEDURES.—The Secretary may promulgate regulations, developed through rulemaking as provided for in section 802, to establish standards and procedures for governing loans and loan guarantees under this section, subject to the following conditions:

"(1) The principal amount of a loan or loan guarantee may cover up to 100 percent of eligible costs, including costs for the planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements,

medical equipment and furnishings, other facility related costs and capital purchase (but excluding staffing).

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

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

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

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

"(6) The Secretary may accept an assignment of the revenue of an Indian tribe or tribal organization as security for any direct loan or loan guarantee under this section.

"(7) In the planning and design of health facilities under this section, users eligible under section

807(b) may be included in any projection of patient population.

"(8) The Secretary shall not collect loan application, processing or other similar fees from Indian tribes or tribal organizations applying for direct loans or loan guarantees under this section.

"(9) Service funds authorized under loans or loan guarantees under this section may be used in matching other Federal funds.

"(c) FUNDING.—

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

"(A) such sums as may be initially appropriated to the HCFLF and as may be subsequently appropriated under paragraph (2);

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

"(C) all interest earned on amounts in the HCFLF.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the

amount collected by the HCFLF during the preceding fiscal year, and all accrued interest on such amounts.

"(3) AVAILABILITY OF FUNDS.—Amounts appropriated, collected or earned relative to the HCFLF shall remain available until expended.

"(d) FUNDING AGREEMENTS.—Amounts in the HCFLF and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service, to make loans under this section to an Indian tribe or tribal organization pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

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

"(f) GRANTS.—The Secretary is authorized to establish a program to provide grants to Indian tribes and trib-

al organizations for the purpose of repaying all or part of any loan obtained by an Indian tribe or tribal organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

"SEC. 311. TRIBAL LEASING.

"Indian Tribes and tribal organizations providing health care services pursuant to a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

"SEC. 312. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

"(a) AUTHORITY.—

"(1) 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 acquisi-

tion 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.

"(2) USE OF RESOURCES.—A tribe or tribal organization may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

"(3) ELIGIBILITY OF CERTAIN ENTITIES.—A tribe that has begun and substantially completed the process of acquisition or construction of a health facility shall be eligible to establish a joint venture project with the Service using such health facility.

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall enter into an arrangement under subsection (a)(1) with an Indian tribe or tribal organization only if—

"(A) 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 health facility described in subsection (a)(1); and

"(B) the Indian tribe or tribal organization meets the needs criteria that shall be developed through the negotiated rulemaking process provided for under section 802.

"(2) CONTINUED OPERATION OF FACILITY.—The Secretary shall negotiate an agreement with the Indian tribe or tribal organization regarding the continued operation of a facility under this section at the end of the initial 10 year no-cost lease period.

"(3) BREACH OR TERMINATION 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 tribe or tribal organization, or paid to a third party on the 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 shall not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

"(d) RECOVERY FOR NON-USE.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility should at any time within 10 years the Service ceases to use the facility or otherwise breaches the agreement.

"(e) DEFINITION.—In this section, the terms 'health facility' or 'health facilities' include staff quarters needed to provide housing for the staff of the tribal health program.

"SEC. 313. LOCATION OF FACILITIES.

"(a) PRIORITY.—The Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

"(b) DEFINITION.—In this section, the term 'Indian lands' means—

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

"(2) any lands title to which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power; and

"(3) all lands in Alaska owned by any Alaska Native village, or any village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

"SEC. 314. 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 that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

"(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

"(1) IN GENERAL.—The Secretary may expend maintenance and improvement funds to support the maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian tribe or tribal organization.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'supportable space allocation' shall be defined through the negotiated rulemaking process provided for under section 802.

"(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

"(1) IN GENERAL.—In addition to using maintenance and improvement funds for the maintenance of facilities under subsection (b)(1), an Indian tribe or tribal organization may use such funds for the construction of a replacement facility if the costs of the renovation of such facility would exceed a maximum renovation cost threshold.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'maximum renovation cost threshold' shall be defined through the negotiated rulemaking process provided for under section 802.

"SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED QUARTERS.

"(a) ESTABLISHMENT OF RENTAL RATES.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the Federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may 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 under paragraph (1), an Indian tribe or tribal organization shall attempt to achieve the following objectives:

"(A) The rental rates should be based on the reasonable value of the quarters to the occupants thereof.

"(B) The rental rates should generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and, subject to the discretion of the Indian tribe or tribal organization, to supply reserve funds for capital repairs and replacement of the quarters.

"(3) ELIGIBILITY FOR QUARTERS IMPROVEMENT AND REPAIR.—Any quarters whose rental

rates are established by an Indian tribe or tribal organization under this subsection shall continue to be eligible for quarters improvement and repair funds to the same extent as other Federally-owned quarters that are used to house personnel in Service-supported programs.

"(4) NOTICE OF CHANGE IN RATES.—An Indian tribe or tribal organization that exercises the authority provided under this subsection shall provide occupants with not less than 60 days notice of any change in rental rates.

"(b) COLLECTION OF RENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), an Indian tribe or a tribal organization that operates Federally-owned quarters pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

"(A) The Indian tribe or tribal organization shall notify the Secretary and the Federal employees involved of its election to exercise its authority to collect rents directly from such Federal employees.

"(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization 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 Indian tribe or tribal organization 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 Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

"(2) RETROCESSION.—If an Indian tribe or tribal organization which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying Federally-owned quarters, such retrocession shall become effective on the earlier of—

"(A) the first day of the month that begins not less than 180 days after the Indian tribe or tribal organization notifies the Secretary of its desire to retrocede; or

"(B) such other date as may be mutually agreed upon by the Secretary and the Indian tribe or tribal organization.

"(c) RATES.—To the extent that an Indian tribe or tribal organization, 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. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

"(a) IN GENERAL.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to the authorization contained in section 318, except that Indian tribes and tribal organizations shall be exempt from such requirements.

"(b) FALSE OR MISLEADING LABELING.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made

in America' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to the authorization contained in section 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(c) DEFINITION.—In 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. 317. OTHER FUNDING FOR FACILITIES.

"Notwithstanding any other provision of law—

"(1) the Secretary may accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design and construct health care facilities for Indians and to place such funds into funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary

and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

"(2) the Secretary may enter into interagency agreements with other Federal or State agencies and other entities and to accept funds from such Federal or State agencies or other entities to provide for the planning, design and construction of health care facilities to be administered by the Service or by Indian tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act in order to carry out the purposes of this Act, together with the purposes for which such funds are appropriated to such other Federal or State agency or for which the funds were otherwise provided;

"(3) 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; and

"(4) the Secretary, acting through the Service, shall establish standards under regulations developed

through rulemaking under section 802, for the planning, design and construction of health care facilities serving Indians under this Act.

"SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE IV—ACCESS TO HEALTH SERVICES

"SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE PROGRAM.

"(a) IN GENERAL.—Any payments received by the Service, by an Indian tribe or tribal organization pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization pursuant to title V of this Act for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care and services to Indians.

"(b) EQUAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act in preference to an Indian beneficiary without such coverage.

"(c) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for benefits under title XVIII of the Social Security Act.

"SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM.

"(a) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such title. Any payments which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes. In making payments from such fund, the Secretary shall ensure that each service unit of the

the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for medical assistance under title XIX of the Social Security Act.

"(b) PAYMENTS DISREGARDED FOR APPROPRIATIONS.—Any payments received under section 1911 of the Social Security Act for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

"(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405.

"SEC. 403. REPORT.

"(a) INCLUSION IN ANNUAL REPORT.—The Secretary shall submit to the President, for inclusion in the

report required to be transmitted to the Congress under section 801, an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements under titles XVIII and XIX of the Social Security Act.

"(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian tribe or tribal organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an urban Indian organization receives funding from the Service under Title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian tribe or tribal organization, or urban Indian organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

"SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and tribal organizations to assist such organizations in establishing and administering programs on or near Federal In-

dian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

"(1) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(2) pay premiums for health insurance coverage; and

"(3) apply for medical assistance provided pursuant to titles XIX and XXI of the Social Security Act.

"(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

"(1) determine the population of Indians to be served that are or could be recipients of benefits or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

"(2) assist individual Indians in becoming familiar with and utilizing such benefits and assistance;

"(3) provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits and assistance;

"(4) develop and implement—

"(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for health insurance coverage of needy individuals; and

"(B) methods of improving the participation of Indians in receiving the benefits and assistance provided under titles XVIII, XIX, and XXI of the Social Security Act.

"(c) AGREEMENTS FOR RECEIPT AND PROCESSING OF APPLICATIONS.—The Secretary may enter into an agreement with an Indian tribe or tribal organization, or an urban Indian organization, which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act and benefits under title XVIII of such Act by a Service facility or a health care program administered by such Indian tribe or tribal organization, or urban Indian organization, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act or a grant or contract entered into with an urban Indian organization under title

V of this Act. Notwithstanding any other provision of law, such agreements shall provide for reimbursement of the cost of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may be included in an encounter rate or be made on a fee-for-service basis as appropriate for the provider. When necessary to carry out the terms of this section, the Secretary, acting through the Health Care Financing Administration or the Service, may enter into agreements with a State (or political subdivision thereof) to facilitate cooperation between the State and the Service, an Indian tribe or tribal organization, and an urban Indian organization.

"(d) GRANTS.—

"(1) IN GENERAL.—The Secretary shall make grants or enter into contracts with urban Indian organizations to assist such organizations in establishing and administering programs to assist individual urban Indians to—

"(A) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(B) pay premiums on behalf of such individuals for coverage under title XVIII of such Act; and

"(C) apply for medical assistance provided under title XIX of such Act and for child health assistance under title XXI of such Act.

"(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or entered into under paragraph (1) requirements that are—

"(A) consistent with the conditions imposed by the Secretary under subsection (b);

"(B) appropriate to urban Indian organizations and urban Indians; and

"(C) necessary to carry out the purposes of this section.

"SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

"(a) DIRECT BILLING.—

"(1) IN GENERAL.—An Indian tribe or tribal organization may directly bill for, and receive payment for, health care services provided by such tribe or organization for which payment is made under title XVIII of the Social Security Act, under a State plan for medical assistance approved under title XIX of such Act, under a State child health plan approved under title XXI of such Act, or from any other third party payor.

"(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act and section 2101(c) of such Act shall apply for purposes of reimbursement under the medicaid or State children's health insurance program for health care services directly billed under the program established under this section.

"(b) DIRECT REIMBURSEMENT.—

"(1) USE OF FUNDS.—Each Indian tribe or tribal organization exercising the option described in subsection (a) of this section shall be reimbursed directly under the medicare, medicaid, and State children's health insurance programs for services furnished, without regard to the provisions of sections 1880(c) of the Social Security Act and section 402(a) of this Act, but all funds so reimbursed shall first be used by the health program for the purpose of making any improvements in the facility or health programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such health services under the medicare, medicaid, or State children's health insurance program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements

shall be used to provide additional health services, improvements in its health care facilities, or otherwise to achieve the health objectives provided for under section 3 of this Act.

"(2) AUDITS.—The amounts paid to the health programs exercising the option described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare, medicaid, and State children's health insurance programs.

"(3) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 401(c) or section 402(a), no payment may be made out of the special fund described in section 401(c) or 402(a), for the benefit of any health program exercising the option described in subsection (a) of this section during the period of such participation.

"(c) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, 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 section,

including any agreements with States that may be necessary to provide for direct billing under the medicaid or State children's health insurance program.

"(d) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

"(e) LIMITATION.—Notwithstanding this section, 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), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the in-

jury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

"(a) RIGHT OF RECOVERY.—Except as provided in subsection (g), the United States, an Indian tribe or tribal organization shall have the right to recover the reasonable charges billed or expenses incurred by the Secretary or an Indian tribe or tribal organization in providing health services, through the Service or 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 reimbursement or indemnification for such charges or expenses if—

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

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

"(b) URBAN INDIAN ORGANIZATIONS.—Except as provided in subsection (g), an urban Indian organization shall have the right to recover the reasonable charges

billed or expenses incurred by the organization in providing health services to any individual to the same extent that such individual, or any other nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if such individual had been required to pay such charges or expenses and did pay such charges or expenses.

"(c) LIMITATIONS ON RECOVERIES FROM STATES.—Subsections (a) and (b) 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.

"(d) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States or an Indian tribe or tribal organization under subsection (a), or an urban Indian organization under subsection (b).

"(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery pro-

vided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

"(f) METHODS OF ENFORCEMENT.—

"(1) IN GENERAL.—The United States or an Indian tribe or tribal organization may enforce the right of recovery provided under subsection (a), and an urban Indian organization may enforce the right of recovery provided under subsection (b), 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 urban Indian organization; or

"(ii) by any representative or heirs of such individual; or

"(B) instituting a civil action.

"(2) NOTICE.—All reasonable efforts shall be made to provide notice of an action instituted in accordance with paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

"(g) LIMITATION.—Notwithstanding this section, 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), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

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

"(i) RIGHT OF ACTION AGAINST INSURERS AND EMPLOYEE BENEFIT PLANS.—

"(1) IN GENERAL.—Where an insurance company or employee benefit plan fails or refuses to pay

the amount due under subsection (a) for services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the United States or an Indian tribe or tribal organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal, State or tribal law.

"(2) URBAN INDIAN ORGANIZATIONS.—Where an insurance company or employee benefit plan fails or refuses to pay the amounts due under subsection (b) for health services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the urban Indian organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal or State law.

"(j) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization, or an urban Indian organization shall have a right of recovery for any otherwise reimbursable claim filed on a current HCFA-

1500 or UB–92 form, or the current NSF electronic format, or their successors. No health plan shall deny payment because a claim has not been submitted in a unique format that differs from such forms.

"SEC. 407. CREDITING OF REIMBURSEMENTS.

"(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87–693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

"(b) NO OFFSET OF FUNDS.—The Service may not offset or limit the amount of funds obligated to any service unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

"SEC. 408. PURCHASING HEALTH CARE COVERAGE.

"An Indian tribe or tribal organization, and an urban Indian organization may utilize funding from the Sec-

retary under this Act to purchase managed care coverage for Service beneficiaries (including insurance to limit the financial risks of managed care entities) from—

"(1) a tribally owned and operated managed care plan;

"(2) a State or locally-authorized or licensed managed care plan; or

"(3) a health insurance provider.

"SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VETERAN'S AFFAIRS, AND OTHER FEDERAL AGENCY HEALTH FACILITIES AND SERVICES SHARING.

"(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

"(1) IN GENERAL.—The Secretary shall examine the feasibility of entering into arrangements or expanding existing arrangements for the sharing of medical facilities and services between the Service and the Veterans' Administration, and other appropriate Federal agencies, including those within the Department, and shall, in accordance with subsection (b), prepare a report on the feasibility of such arrangements.

"(2) SUBMISSION OF REPORT.—Not later than September 30, 2000, the Secretary shall submit the report required under paragraph (1) to Congress.

"(3) CONSULTATION REQUIRED.—The Secretary may not finalize any arrangement described in paragraph (1) without first consulting with the affected Indian tribes.

"(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;

"(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 Veterans' Administration;

"(4) the quality of health care services provided to any veteran by the Veteran's Administration;

"(5) the eligibility of any Indian to receive health services through the Service; or

"(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration provided, however, the Service or the

Indian tribe or tribal organization shall be reimbursed by the Veterans' Administration where services are provided through the Service or Indian tribes or tribal organizations to beneficiaries eligible for services from the Veterans' Administration, notwithstanding any other provision of law.

"(c) AGREEMENTS FOR PARITY IN SERVICES.—The Service may enter into agreements with other Federal agencies to assist in achieving parity in services for Indians. Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Service.

"SEC. 410. PAYOR OF LAST RESORT.

"The Service, and programs operated by Indian tribes or tribal organizations, or urban Indian organizations shall be the payor of last resort for services provided to individuals eligible for services from the Service and such programs, notwithstanding any Federal, State or local law to the contrary, unless such law explicitly provides otherwise.

"SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH CARE PROGRAMS.

"Notwithstanding any other provision of law, the Service, Indian tribes or tribal organizations, and urban Indian organizations (notwithstanding limitations on who

is eligible to receive services from such entities) shall be entitled to receive payment or reimbursement for services provided by such entities from any Federally funded health care program, unless there is an explicit prohibition on such payments in the applicable authorizing statute.

"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

"(a) IN GENERAL.—Notwithstanding any other provision of law, including the Anti-Deficiency Act, provided the Indian tribes to be served approve, the Service in the Tuba City Service Unit may—

"(1) enter into a demonstration project with the State of Arizona under which the Service would provide certain specified medicaid services to individuals dually eligible for services from the Service and for medical assistance under title XIX of the Social Security Act in return for payment on a capitated basis from the State of Arizona; and

"(2) purchase insurance to limit the financial risks under the project.

"(b) EXTENSION OF PROJECT.—The demonstration project authorized under subsection (a) may be extended to other service units in Arizona, subject to the approval of the Indian tribes to be served in such service units, the Service, and the State of Arizona.

"SEC. 413. ACCESS TO FEDERAL INSURANCE.

"Notwithstanding the provisions of title 5, United States Code, Executive Order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.

"SEC. 414. CONSULTATION AND RULEMAKING.

"(a) CONSULTATION.—Prior to the adoption of any policy or regulation by the Health Care Financing Administration, the Secretary shall require the Administrator of that Administration to—

"(1) identify the impact such policy or regulation may have on the Service, Indian tribes or tribal organizations, and urban Indian organizations;

"(2) provide to the Service, Indian tribes or tribal organizations, and urban Indian organizations the information described in paragraph (1);

"(3) engage in consultation, consistent with the requirements of Executive Order 13084 of May 14, 1998, with the Service, Indian tribes or tribal organizations, and urban Indian organizations prior to enacting any such policy or regulation.

"(b) RULEMAKING.—The Administrator of the Health Care Financing Administration shall participate in the negotiated rulemaking provided for under title VIII with regard to any regulations necessary to implement the provisions of this title that relate to the Social Security Act.

"SEC. 415. LIMITATIONS ON CHARGES.

"No provider of health services that is eligible to receive payments or reimbursements under titles XVIII, XIX, or XXI of the Social Security Act or from any Federally funded (whether in whole or part) health care program may seek to recover payment for services—

"(1) that are covered under and furnished to an individual eligible for the contract health services program operated by the Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an

urban Indian organization, in an amount in excess of the lowest amount paid by any other payor for comparable services; or

"(2) for examinations or other diagnostic procedures that are not medically necessary if such procedures have already been performed by the referring Indian health program and reported to the provider.

"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHORITY.

"Notwithstanding any other provision of law, the Secretary may not waive the application of section 1902(a)(13)(D) of the Social Security Act to any State plan under title XIX of the Social Security Act.

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

"Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

"(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

"(1) any Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act;

"(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

"(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2000); or

"(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of

pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization; provided the exchange arises from or relates to such health programs.

"(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES AND PREMIUMS.

"(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an In-

dian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

"(b) EXEMPTION FROM PREMIUMS.—

"(1) MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for medical assistance under title XIX of the Social Security Act or child health assistance under title XXI of such Act may be charged a premium as a condition of receiving such assistance under title XIX of XXI of such Act.

"(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security

Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian Tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

"For the purpose of determining the eligibility under section 1902(a)(10)(A)(ii)(IV) of the Social Security Act of an Indian for medical assistance under a State plan under title XIX of such Act, the cost of providing services to an Indian in a health program of the Service, an Indian Tribe or tribal organization, or an urban Indian organization shall be deemed to have been an expenditure for health care by the Indian.

"SEC. 421. ESTATE RECOVERY PROVISIONS.

"Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of

the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

"(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

"(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

"(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

"(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

"SEC. 422. MEDICAL CHILD SUPPORT.

"Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization.

For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian Tribe or tribal organization or an urban Indian organization and another health provider.

"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

"(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian Tribe or tribal organization or an urban Indian organization shall have a right of recovery under section 408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian Tribe or tribal organization or an urban Indian organization.

"(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement

may not be made a prerequisite for such payments to be made.

"(c) PARITY.—Payments due under subsection (a) from a managed care entity may not be paid at a rate that is less than the rate paid to a 'preferred provider' by the entity or, in the event there is no such rate, the usual and customary fee for equivalent services.

"(d) NO CLAIM REQUIREMENT.—A managed care entity may not deny payment under subsection (a) because an enrollee with the entity has not submitted a claim.

"(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

"(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered

by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

"(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under any managed care entity participating in a State plan under title XIX or XXI of the Social Security Act unless the Indian had the option of enrolling in a managed care plan or health program administered by the Service, an Indian tribe or tribal organization, or an urban Indian organization.

"(h) INDIAN MANAGED CARE PLANS.—Notwithstanding any other provision of law, any State entering into agreements with one or more managed care organizations to provide services under title XIX or XXI of the Social Security Act shall enter into such an agreement with the Service, an Indian tribe or tribal organization or an urban Indian organization under which such an entity may provide services to Indians who may be eligible or required to enroll with a managed care organization

through enrollment in an Indian managed care organization that provides services similar to those offered by other managed care organizations in the State. The Secretary and the State are hereby authorized to waive requirements regarding discrimination, capitalization, and other matters that might otherwise prevent an Indian managed care organization or health program from meeting Federal or State standards applicable to such organizations, provided such Indian managed care organization or health program offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

"(i) ADVERTISING.—A managed care organization entering into a contract to provide services to Indians on or near an Indian reservation shall provide a certificate of coverage or similar type of document that is written in the Indian language of the majority of the Indian population residing on such reservation.

"SEC. 424. NAVAJO NATION MEDICAID AGENCY.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary may treat the Navajo Nation as a State under title XIX of the Social Security Act for purposes of providing medical assistance to Indians living within the boundaries of the Navajo Nation.

"(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and

pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

"(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

"(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such Nation, include Western and traditional Navajo healing services) within the Navajo Nation. Such assistance may include providing funds for demonstration projects conducted with such Nation.

"(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per cent with respect to amounts the Navajo Nation Medicaid agency expends for medical assistance and related administrative costs.

"(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of Title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

"(g) SCHIP.—At the option of the Navajo Nation, the Secretary may treat the Navajo Nation as a State for purposes of title XXI of the Social Security Act under terms equivalent to those described in the preceding subsections of this section.

"SEC. 425. INDIAN ADVISORY COMMITTEES.

"(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall

include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

"(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

"SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title.".

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"SEC. 501. PURPOSE.

"The purpose of this title is to establish programs in urban centers to make health services more accessible and available to urban Indians.

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

"Under the authority of the Act of November 2, 1921 (25 U.S.C. 13)(commonly known as the Snyder Act), the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within urban centers, of programs which meet the requirements set forth in this title. The Secretary, through the Service, subject to section 506, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

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

"(a) AUTHORITY.—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 enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

"(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

"(2) estimate the current health status of urban Indians residing in such urban center or centers;

"(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

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

"(5) make recommendations to the Secretary and Federal, State, local, and other resource 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 adopted pursuant to section 520 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;

"(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) HEALTH PROMOTION AND DISEASE PREVENTION.—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 pursuant to this section or receiving grants under subsection (a).

"(d) IMMUNIZATION SERVICES.—

"(1) IN GENERAL.—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.

"(3) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

"(e) MENTAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) ASSESSMENT.—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 mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(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; and

"(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

"(f) CHILD ABUSE.—

"(1) IN GENERAL.—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 pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

"(2) ASSESSMENT.—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) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

"(C) 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.—In making grants to carry out this subsection, the Secretary shall take into consideration—

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

Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

"(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

"(C) the assessment required under paragraph (2).

"(g) MULTIPLE URBAN CENTERS.—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 one urban center.

"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

"(a) AUTHORITY.—

"(1) IN GENERAL.—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.

"(2) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(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.

"(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake 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 organization receives such grant, whichever is applicable.

"(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

"(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title 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) COMPLIANCE WITH TERMS.—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 of grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

"(1) conduct, through the Service, an annual onsite evaluation of the organization; or

"(2) accept, in lieu of an 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.—

"(1) IN GENERAL.—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 such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

"(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with

such 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) DETERMINATION OF RENEWAL.—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, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

"(a) APPLICATION OF FEDERAL LAW.—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 the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

"(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

"(1) be made in their entirety by the Secretary to the urban Indian organization by not later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

"(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the expenditure of such funds.

"(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or 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 PROVISION OF SERVICES.—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.

"(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indians, as defined in section 4(f), shall be eligible for health care or referral services provided pursuant to this title.

"SEC. 507. REPORTS AND RECORDS.

"(a) REPORT.—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 organization shall submit to the Secretary, on a basis no more frequent than every 6 months, a report including—

"(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract or grant;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary,

after consultations consistent with section 514, with urban Indian organizations.

"(b) AUDITS.—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) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

"(1) a certified public accountant; or

"(2) a certified public accounting firm qualified to conduct Federal compliance audits.

"SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

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

"SEC. 509. FACILITIES.

"(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

"(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

"(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

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

"(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility, or 25 years.

"(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the

revenue of the organization as security for a loan or loan guarantee under this subsection.

"(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

"(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

"(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

"(A) such amounts as may be appropriated to the URLF;

"(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

"(C) interest earned on amounts in the URLF under paragraph (3).

"(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the

requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

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

"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

"There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

"(1) carrying out the provisions of this title;

"(2) providing central oversight of the programs and services authorized under this title; and

"(3) providing technical assistance to urban Indian organizations.

"SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES.

"(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom the Secretary has entered into a contract under this title or under section 201.

"(b) GOALS OF GRANT.—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—

"(1) 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, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

"(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

"(a) OKLAHOMA CITY CLINIC.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Oklahoma City Clinic demonstration project shall be treated as a service unit in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.

"(2) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and con-

clusions derived from the demonstration project specified in paragraph (1).

"(b) TULSA CLINIC.—Notwithstanding any other provision of law, the Tulsa Clinic demonstration project shall become a permanent program within the Service's direct care program and continue to be treated as a service unit in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

"(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2001, with urban Indian organizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section 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 NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

"(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

"SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

"(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension

and which emphasizes trust, respect, and shared responsibility.

"SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

"For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian orga-

nization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

"(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting.

"(b) STATES.—A State described in this subsection is a State in which—

"(1) there reside urban Indian youth with a need for alcohol and substance abuse treatment services in a residential setting; and

"(2) there is a significant shortage of culturally competent residential treatment services for urban Indian youth.

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

"(a) IN GENERAL.—The Secretary shall 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) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the

General Services Administration for purposes of carrying out the contract or grant.

"(c) ACQUISITION OF PROPERTY.—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 on which the Secretary transfers title to the property or, if earlier, the date on which the Secretary transfers the property physically, to the urban Indian organization.

"(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—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, in-

cluding lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

"(a) AUTHORITY.—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, treatment, 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 upon between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

"(1) the size and location of the urban Indian population to be served;

"(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

"(3) performance standards for the urban Indian 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 urban Indian organization to adequately perform the activities required under the grant; and

"(5) the willingness of the urban Indian 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) APPLICATION OF CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

"SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

"The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health

service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

"SEC. 520. REGULATIONS.

"(a) EFFECT OF TITLE.—This title shall be effective on the date of enactment of this Act regardless of whether the Secretary has promulgated regulations implementing this title.

"(b) PROMULGATION.—

"(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

"(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270 days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

"(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursu-

ant to section 565 of title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

"(d) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of this Act.

"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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

"(a) ESTABLISHMENT.—

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

"(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance 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, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

"(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) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

"(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for,

and provision and utilization of, health services for Indians;

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

"(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

"(4) all scholarship and loan functions carried out under title I.

"(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).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, 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;

"(C) a privacy component that protects the privacy of patient information;

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

"(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

"(2) meet the management information needs of the Service.

"(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable

access to the medical or health records of such patient which are held by, or on behalf of, the Service.

"(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the 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.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

"(a) PURPOSES.—It is the purpose of this section to—

"(1) authorize and direct the Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration

among alcohol and substance abuse, social services, and mental health programs;

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

"(3) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

"(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

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

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

"(b) BEHAVIORAL HEALTH PLANNING.—

"(1) AREA-WIDE PLANS.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for Indian Behavioral Health Services. The plans shall, to the extent feasible, include—

"(A) an assessment of the scope of the problem of alcohol or other substance abuse, mental illness, 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; and

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

"(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

"(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 shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such 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 utilized and adopted locally.

"(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

"(1) a comprehensive continuum of behavioral health care that provides for—

"(A) community based prevention, intervention, outpatient and behavioral health aftercare;

"(B) detoxification (social and medical);

"(C) acute hospitalization;

"(D) intensive outpatient or day treatment;

"(E) residential treatment;

"(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

"(G) emergency shelter;

"(H) intensive case management; and

"(I) traditional health care practices; and

"(2) behavioral health services for particular populations, including—

"(A) for persons from birth through age 17, child behavioral health services, that include—

"(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

"(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (multiple diagnosis);

"(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

"(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

"(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

"(vii) co-morbidity services;

"(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

"(i) early intervention, treatment and aftercare services;

"(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

"(iv) healthy choices and life style services (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

"(v) female specific treatment services for—

"(I) women at risk of giving birth to a child with a fetal alcohol disorder;

"(II) substance abuse requiring gender specific services;

"(III) sexual assault and domestic violence; and

"(IV) healthy choices and life style (parenting, partners, obesity,

suicide and other related behavioral risk); and

"(vi) male specific treatment services for—

"(I) substance abuse requiring gender specific services;

"(II) sexual assault and domestic violence; and

"(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

"(C) family behavioral health services, including—

"(i) early intervention, treatment and aftercare for affected families;

"(ii) treatment for sexual assault and domestic violence; and

"(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

"(D) for persons age 56 years and older, elder behavioral health services including—

"(i) early intervention, treatment and aftercare services that include—

"(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

"(III) healthy choices and life style services (managing conditions related to aging);

"(ii) elder women specific services that include—

"(I) treatment for substance abuse requiring gender specific services and

"(II) treatment for sexual assault, domestic violence and neglect;

"(iii) elder men specific services that include—

"(I) treatment for substance abuse requiring gender specific services; and

"(II) treatment for sexual assault, domestic violence and neglect; and

"(iv) services for dementia regardless of cause.

"(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

"(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, 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 alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

"(2) TECHNICAL ASSISTANCE.—In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe

or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

"(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting 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) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

"(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conver-

sion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

"SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

"(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 mental 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 mental health services to which all citizens have access;

"(B) the right of Indians to participate in, and receive the benefit of, such services; and

"(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 health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

"(6) a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

"(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diag-

nosed individuals requiring mental health and substance abuse treatment; and

"(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

"(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to 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); and

"(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

"(b) SPECIFIC PROVISIONS.—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 Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

"(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

"(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

"(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

"(1) Indian tribes and tribal organizations;

"(2) Indian individuals;

"(3) urban Indian organizations and other Indian organizations;

"(4) behavioral health service providers.

"(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Fed-

eral Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

"SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including traditional health care practices, which shall include—

"(A) prevention, through educational intervention, in Indian communities;

"(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

"(C) community-based rehabilitation and aftercare;

"(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

"(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children.

"(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

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

"SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

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

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

"(b) TRAINING.—In carrying out subsection (a)(1), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

"(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

"(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section

Indian health care and treatment practices of the Indian tribes to be served.–

"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

"Subject to section 220, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

"(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling psychologist;

"(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

"(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

"(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

"(b) USE OF FUNDS.—Funding provided 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 pro-

"(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 707. INDIAN YOUTH PROGRAM.

"(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

"(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment

center or treatment network in each area under the jurisdiction of an area office.

"(B) AREA OFFICE IN CALIFORNIA.—For 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 centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

"(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) that is agreed upon (by appropriate tribal resolution) by a majority of the 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;

"(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));

"(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

"(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treat-

ment Center, a residential youth treatment facility in New Mexico.

"(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—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 youth residing in such State.

"(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes and tribal organizations, may provide intermediate behavioral health services, which may incorporate traditional health care practices, to Indian children and adolescents, including—

"(A) pre-treatment assistance;

"(B) inpatient, outpatient, and after-care 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; and

"(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

"(E) intensive home and community based services.

"(3) CRITERIA.—The Secretary 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, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

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

"(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

"(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

"(e) REHABILITATION AND AFTERCARE SERVICES.—

"(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and imple-

ment within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

"(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used

for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

"(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youth residing in Indian communities, on Indian reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youth.

"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION AND STAFFING ASSESSMENT. —

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems.

"(b) TREATMENT OF CALIFORNIA.—For purposes of this section, California shall be considered to be 2 areas of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California

and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

"(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.–

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

"(a) COMMUNITY EDUCATION.—

"(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each service unit or tribal program a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community.

"(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

"(3) TRAINING.—Community-based training (oriented toward local capacity development) under a

program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

"(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders, to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

"(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and

provide community-based training models. Such models shall address—

"(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

"(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 710. BEHAVIORAL HEALTH PROGRAM.

"(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian Tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

"(1) Whether the project will address significant unmet behavioral health needs among Indians.

"(2) Whether the project will serve a significant number of Indians.

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

"(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

"(5) Whether the project will deliver services in a manner consistent with traditional health care.

"(6) Whether the project is coordinated with, and avoids duplication of, existing services.

"(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

"(a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the pur-

poses of meeting the health status objective specified in section 3(b).

"(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

"(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

"(B) identify and provide behavioral health treatment to high-risk women;

"(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

"(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

"(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

"(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

"(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

"(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

"(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

"(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

"(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

"(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the

special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

"(c) TASK FORCE.—

"(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

"(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

"(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian

Tribes, tribal organizations and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol disorders.

"(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

"(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

"(1) victims of child sexual abuse; and

"(2) perpetrators of child sexual abuse.

"(b) USE OF FUNDS.—Funds provided under this section shall be used to—

"(1) develop and provide community education and prevention programs related to child sexual abuse;

"(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

"(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

"(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

"(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made 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 to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

"SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

"(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, tribal organizations and urban Indian organizations or, enter into

contracts with, or make grants to appropriate institutions, for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

"(1) the inter-relationship and inter-dependance of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

"(2) the development of models of prevention techniques.

"(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

"SEC. 714. DEFINITIONS.

"In this title:

"(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis and dissemination of information on health status, health needs and health problems.

"(2) ALCOHOL RELATED NEURODEVELOP-MENTAL DISORDERS.—The term 'alcohol related

neurodevelop-mental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(4) BEHAVIORAL HEALTH AFTERCARE.—

"(A) IN GENERAL.—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, to help prevent or treat relapse, including the development of an aftercare plan.

"(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

"(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.–

"(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

"(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be met:

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

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

"(C) Prenatal or postnatal growth delay.

"(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means a history of maternal alcohol consumption during pregnancy having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

"(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.–

"(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse. —

"SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VIII—MISCELLANEOUS

"SEC. 801. REPORTS.

"The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—

"(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population, including specific comparisons of appropriations provided and those required for such parity;

"(2) a report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the allocation of funding pursuant to section 808;

"(3) a report on the use of health services by Indians—

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

"(B) by gender and age;

"(C) by source of payment and type of service;

"(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

"(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

"(4) a report of contractors concerning health care educational loan repayments under section 110;

"(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

"(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

"(7) a report on infectious diseases as required under section 212;

"(8) a report on environmental and nuclear health hazards as required under section 214;

"(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

"(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

"(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

"(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

"(13) a report providing an accounting of reimbursement funds made available to the Secretary

under titles XVIII and XIX of the Social Security Act as required under section 403(a);

"(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

"(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

"(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

"(17) a report on the evaluation of programs as required under section 513; and

"(18) a report on alcohol and substance abuse as required under section 701(f).

"SEC. 802. REGULATIONS.

"(a) INITIATION OF RULEMAKING PROCEDURES.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, 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.

"(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

"(b) RULEMAKING COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of Title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian tribes, and tribal organizations, a majority of whom shall be nominated by and be representatives of Indian tribes, tribal organizations, and urban Indian organizations from each service area.

"(c) ADAPTION 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) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

"(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

"SEC. 803. PLAN OF IMPLEMENTATION.

"Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

"SEC. 804. AVAILABILITY OF FUNDS.

"Amounts appropriated under this Act shall remain available until expended.

"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

"Any limitation on the use of funds contained in an Act providing appropriations for the Department for a pe-

riod with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a Federally recognized Indian tribe.

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

"(A) is a member of the Indian community served by a local program of the Service; and

"(B) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of

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

"(b) RULE OF CONSTRUCTION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

"(a) INELIGIBLE PERSONS.—

"(1) IN GENERAL.—Any individual who—

"(A) has not attained 19 years of age;

"(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

"(C) is not otherwise eligible for the health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has

been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

"(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the 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.

"(b) PROGRAMS AND SERVICES.—

"(1) PROGRAMS.—

"(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other

subsection of this section or under any other provision of law if—

"(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

"(ii) the Secretary and the Indian tribe or 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 program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

"(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under

such funding agreement is authorized to determine whether health services should be provided under such funding agreement 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 subparagraph (A)(ii).

"(2) LIABILITY FOR PAYMENT.—

"(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the

account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

"(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be 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 person.

"(3) SERVICE AREAS.—

"(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing

body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

"(c) PURPOSE FOR PROVIDING 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 subsection of this section or under any other provision of law in order to—

"(1) achieve stability in a medical emergency;

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

"(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or

"(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

"(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

"(e) DEFINITION.—In this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

"SEC. 808. REALLOCATION OF BASE RESOURCES.

"(a) REQUIREMENT OF REPORT.—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 the

President, for inclusion in the report required to be transmitted to the 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) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

"SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

"The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

"SEC. 810. PROVISION OF SERVICES IN MONTANA.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr. 1987).

"(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

"During the period of the moratorium imposed by Public Law 100–446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

"For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, Chapter 372), an Indian tribe or tribal organization carrying out a funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

"For purposes of section 4 of Public Law 102–585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be deemed to be an executive agency and part of the Service

Service and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

"(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

"(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

"(1) Ten members of Congress, of which—

"(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

"(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

"(C) two members shall be from the Senate and shall be appointed by the majority leader; and

"(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the pro-

vision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

"(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected by the Indian tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

"(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian Tribes.

"(c) TERMS.—

"(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

"(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

"(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

"(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

"(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

"(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian Tribes;

"(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

"(A) to the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian tribes, tribal organizations and urban Indian organizations, and which may include authorizing and funding feasibility studies of various models for providing and funding health services for all Indian beneficiaries including those who live outside of a reservation, temporarily or permanently;

"(B) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provide,d and the

cost, including mechanisms for funding of the health services to be provided;

"(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

"(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

"(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each Federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

"(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

"(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a

recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

"(e) ADMINISTRATIVE PROVISIONS.—

"(1) COMPENSATION AND EXPENSES.—

"(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

"(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), while serving on the business of the Commission (including travel time) shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States

Code, and while so serving away from home and the member's regular place of business, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(2) MEETINGS AND QUORUM.—

"(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

"(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

"(3) DIRECTOR AND STAFF.—

"(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

"(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

"(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

"(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

"(E) FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals

required for the proper functioning of the Commission.

"(f) POWERS.—

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

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

"(3) COST ESTIMATES.—

"(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

"(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

"(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any federal Agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the federal employee.

"(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal Agency shall provide such technical assistance to the

Commission as the Commission determines to be necessary to carry out its duties.

"(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal Agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

"(7) OBTAINING INFORMATION.—The Commission may secure directly from the any Federal Agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

"(8) SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

"(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

"SEC. 815. APPROPRIATIONS; AVAILABILITY.

"Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

"SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.".

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by adding a semicolon at the end;

(2) in subparagraph (S), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.".

SEC. 202. INDIAN HEALTH PROGRAMS.

Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended to read as follows:

"INDIAN HEALTH PROGRAMS

"SEC. 1880. (a) ELIGIBILITY FOR PAYMENTS.—The Indian Health Service (referred to in this section as the

an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization meets the conditions and requirements for such payments which are applicable generally to the service or provider type for which the Service, Indian tribe or tribal organization, or urban Indian organization seeks payment under this title and for services and provider types provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Service, an Indian tribe or tribal organization, or urban Indian organization, does not meet all of the conditions and requirements of this title which are applicable generally to the service or provider type for which payment is sought, but submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compli-

ance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act.

"(d) COMMUNITY HEALTH AIDES.—The Service or an Indian Tribe or tribal organization providing a service otherwise eligible for payment under this section through the use of a community health aide or practitioner certified under the provisions of section 121 of the Indian Health Care Improvement Act shall be paid for such services on the same basis that such services are reimbursed under State plans approved under title XIX.

"(e) TREATMENT OF CERTAIN PROGRAMS.—Notwithstanding any other provision of law, a health program operated by the Service or an Indian tribe or tribal organization, which collaborates with a hospital operated by the Service or an Indian tribe or tribal organization, shall, at the option of the Indian tribe or tribal organization, be paid for services for which it would otherwise be eligible

for under this as if the health program were an outpatient department of the hospital. In situations where the health program is on a separate campus from the hospital, billing as an outpatient department of the hospital shall not subject such a health program to the requirements of section 1867.

"(f) PAYMENT FOR CERTAIN NURSING SERVICES.—The Service or an Indian tribe or tribal organization providing visiting nurse services in a home health agency shortage area shall be paid for such services on the same basis that such services are reimbursed under this title for other primary care providers.

"(g) ALTERNATIVE METHODS OF REIMBURSEMENT.—Notwithstanding any other provision of law, the Secretary may identify and implement alternative methods of reimbursing Indian health programs for services reimbursable under this title that are provided to Indians, so long as such methods—

"(1) allow an Indian tribe or tribal organization or urban Indian organization to opt to receive reimbursement under reimbursement methodologies applicable to other providers of similar services; and

"(2) provide that the amount of reimbursement resulting under any such methodology shall not be less than 100 percent of the reasonable cost of the

service to which the methodology applies under section 1861(v).".

SEC. 203. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

"QUALIFIED INDIAN HEALTH PROGRAM

"SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

"(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by—

"(A) the Indian Health Service;

"(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; and

"(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

"(2) INCLUDED PROGRAMS AND ENTITIES.—

home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

"(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

"(c) DETERMINATION OF PAYMENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

"(2) DEFINITION OF FULL COST RECOVERY.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

"(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into ac-

count the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

"(ii) indirect costs which, in the case of a qualified Indian health program—

"(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

"(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

"(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or

deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

"(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

"(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

"(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

"(B) NO SINGLE REPORT REQUIREMENT.—Not all health programs provided or administered by the Indian Health Service, an

Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

"(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report shall be made on a fee-for-service, encounter, or per diem basis.

"(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

"(A) a significant decrease in discharges;

"(B) costs for graduate medical education programs;

"(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

"(D) payment for outlier cases.

"(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

"(A) on the full cost recovery basis provided in paragraphs (1) through (5);

"(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

"(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

"(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian Tribe or tribal organization; or

"(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

"(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

"(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

"(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

"(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

"(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health setting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

"(C) preventive primary health services as described under sections 329, 330, and 340 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

"(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screen-

ing, diagnostic, and treatment services as described in section 1905(r);

"(E) influenza and pneumococcal immunizations;

"(F) other immunizations for prevention of communicable diseases when targeted; and

"(G) the cost of transportation for providers or patients necessary to facilitate access for patients.".

Subtitle B—Medicaid

SEC. 211. PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.

Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended—

(1) in subparagraph (B), by striking "and" at the end;

(2) in subparagraph (C), by adding "and" at the end; and

(3) by adding at the end the following:

"(D)(i) for payment for services described in section 1905(a)(2)(C) under the plan furnished by an Indian tribe or tribal organization or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) of 100 percent of costs which are

reasonable and related to the cost of furnishing such services or based on other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, the same methodology used under section 1833(a)(3), and

"(ii) in the case of such services furnished pursuant to a contract between a Federally-qualified health center and a medicaid managed care organization under section 1903(m), for payment to the Federally-qualified health center at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract.".

SEC. 212. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (65), by striking the period; and

(2) by inserting after (65), the following:

"(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

"(A) the term 'meaningful consultation' is defined through the negotiated rulemaking process provided for under section 802 of the Indian Health Care Improvement Act; and

"(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.".

SEC. 213. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

"Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.".

SEC. 214. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

"INDIAN HEALTH SERVICE PROGRAMS

"SEC. 1911. (a) IN GENERAL.—The Indian Health Service and an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as such Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable gen-

under this title and for services provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations and urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian

Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking "For purposes" and inserting the following:

"(1) IN GENERAL.—Subject to paragraph (2), for purposes"; and

(2) by adding at the end the following:

"(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).".

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting "an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)" after "Service".

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

"(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

"(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

"(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

"(2) under an agreement entered into under subsection (a) between the entity and the Secretary.".

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101–630 (25 U.S.C. 1653 note) is repealed.

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. 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.

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Senator DORGAN. The suggestion for this field hearing came from the Aberdeen Area Tribal Chairmen's Health Board. Many of you are here today, and Senator Conrad and I were pleased to add our support to your request. We appreciate Senator Campbell's support and that's what has resulted in this hearing.

The purpose of today's hearing is to give tribal leaders and tribal members an opportunity to testify for the record on the issues of concern about health care at the local level with particular emphasis on the needs of the Aberdeen Area and on the portions of the reauthorization legislation that was not covered in earlier hearings. So we're going to talk about several specific areas, and we will have a brief open-mike period at the end of this, as well, for you to raise whatever you would like to raise.

Panel I will talk about behavioral health concerns in Indian country; panel II, eligibility, entitlement and funding issues; and panel III will be on access to prescription drugs. Those are areas that have not been covered by previous hearings, but we will go beyond that, as well, with respect to other issues you may want to raise.

Let me just say by way of introduction, and then I'll call on my colleague, Senator Conrad, for a few comments, that in my judgment we have a true emergency with respect to Indian health care. If you look at all of the evidence, the mortality rate, the high incidence of diseases, the difficulty of people who are living on American Indian reservations have accessing routine health care, it is staggering.

The rate of diabetes on some of our reservations is not double or triple or quadruple the rate in this country; it is in some cases 10, 12 and 14 times more prevalent than in the general population. The rate of heart disease, the rate of substance abuse, the evidence of suicide, there are so many issues that confront us.

I was on an Indian reservation recently where they have only one dentist who operates in a trailer. I'm sure that dentist works hard all day long and does the best he can, but it's just not enough dentistry to provide the kind of dental care the people on that reservation need. So when you take a look at the health challenges facing senior citizens, children and others living on our Indian reservations, you know and I know that we have a true emergency. We also have an emergency in housing and emergencies in a number of areas, but this hearing today is to focus on the health care crisis, and I hope that with the witnesses that we have gathered that we can have some good input for this hearing record and that we can produce a good piece of legislation in the Reauthorization Act.

We're asking if the witnesses would confine their testimony to 5 minutes. I apologize for that, but we have a large number of witnesses and we also want to be able to hear other people. So with that let me thank my colleague, Senator Conrad, who with me is a member of the Indian Affairs Committee and works tirelessly on

STATEMENT OF HON. KENT CONRAD, U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you, Senator Dorgan, and special thanks to you for arranging this hearing. I think this is a critically important hearing because, without question, health care in Indian country is in crisis. We can only look to the figures of the Indian Health Service itself for the evidence that we have a crisis in health care in Indian country.

Life expectancy in the Aberdeen Area for Native Americans is 10 years less than for the general population in this country. Suicide is 70 percent higher, and on the Standing Rock Tribe among our youth, age 10 to 25, the suicide rate is 16 times the general population in this country. What could be more clear than we have a crisis?

In North Dakota, as in many other parts of the country, a Native American population is dependent on contract care. Contract care because of a shortage of funds requires that a patient must fall within the priority one category. That means a patient must have a life- or limb-threatening illness or injury to receive care from a contract care provider.

Think of what that means. You've got to be in a life- or limb-threatening circumstance to receive care. There is no other part of society where we would accept that standard, and it ought not to be accepted here.

That is the fundamental question before us. What are we going to do to make certain that all of our people have access to the health care that they need and deserve? That's why this hearing is so important.

I want to say a special thanks to Chairman Ben Nighthorse Campbell for permitting this hearing to be held in North Dakota. I think we should acknowledge it is an unusual circumstance for a chairman to permit Senators from the other side of the aisle to conduct an official hearing on behalf of the committee. I think that speaks to the seriousness that Senator Campbell brings this task. We have enjoyed a close working relationship with Senator Campbell ever since he came to the Senate, and through his staff we want to express to him our great gratitude for his willingness to allow us to conduct this hearing.

I look forward, Senator Dorgan, to the witnesses, and I hope very much that this message is received loud and clear. This is our chance to put on the record the critical nature of health care in Indian country. So let's make it a full and complete one so this message can be heard. Thank you.

Senator DORGAN. Senator Conrad, thank you very much. We have scheduled 2 hours for this hearing, and we have to be completed by 11:30. So we will ask all of our witnesses to cooperate and thank all of you very much.

Before we begin to hear the witnesses I would like to call on Charlie Murphy, who is the chairman of the Standing Rock Tribe, and also chairman of the board of the United Tribes Technical Col-

Mr. MURPHY. Yes; welcome, that's it. Thank you. No. We want to thank Senator Dorgan and Senator Kent Conrad for coming out here for the field hearing because it's very important, and the needs that we have out here in Indian country, particularly in the Aberdeen Area, is that we do not have enough dollars to provide for our people within the reservations, and a lot of our tribes are using casino dollars and other dollars to try to meet the unmet needs for our people.

So with that, Senator Dorgan and Senator Kent Conrad, thank you very much for coming here.

Senator DORGAN. Charlie, thank you very much, and, David, now that you're in the room, let us say thank you as well for being such a wonderful host. I'd like to just mention to all of you that about 3 years ago, I believe it was, Kent, that there was a proposal in the U.S. Congress to close this college and zero out Federal funding for this college, and Senator Conrad and I were able to work to get funding restored in the Senate appropriations bill. Those who were trying to close UTTC have finally stopped those efforts, and I am pleased to say that we now have stable funding for this college. I think people who previously thought UTTC ought to close now understand the value of investing in people here by education and by investing in their lives. So it's nice to be here at a wonderful facility that's making a difference in people's lives and nice to have played some small role with you, David, my colleague, Senator Conrad and others, to say this place matters for a lot of people, and we're glad you're here.

So, with that, we will move on to our witnesses. The first panel is Phillip "Skip" Longie, who is the chairman of the Spirit Lake Tribe in Fort Totten, ND, and also Deborah Painte, director of the Sacred Child Program, United Tribes Technical College in Bismarck. We will turn to you, Chairman Longie. Why don't you proceed.

Mr. LONGIE. Before we start, I'd like to have one of our elders say a prayer, which is usually one of our customs, to give us the thoughts for today.

[Prayer in Native tongue.]

Senator DORGAN. Thank you very much. And I will—for all of the witnesses, Senator Conrad and I will at the end of 5 minutes just gently, ever so gently, interrupt and ask if you will summarize. Thank you very much.

Chairman Longie please proceed.

STATEMENT OF PHILLIP "SKIP" LONGIE, CHAIRMAN, SPIRIT LAKE TRIBE, FORT TOTTEN, ND, ACCOMPANIED BY LARRY DAUPHANAIS, IHS DISTRICT SANITARIAN

Mr. LONGIE. Thank you, Senator Dorgan, Senator Conrad. Before I start, I'd like to point out that I read this the other night and it took me 8 minutes. So what I'm going to do—I've got a bunch of drafts and bullets in here, and I might just touch on those. Okay.

I welcome you to the Aberdeen Area and the State of North Dakota.

Initially I want to state my support for the draft health care legislation to reauthorize the Indian Health Care Improvement Act, S 2526. I will briefly point out some of the health care issues related to section VII, behavioral health prevention and treatment services more specifically injury prevention and its relationship to health care cost and its impact on morbidity and mortality of our American Indian people.

As a tribal leader, member of the Aberdeen Area Tribal Chairmen's Board and area representative to the National Level of Need Work Group, it is evident daily the impacts of inequities and disparities in health care provision affecting our Indian people. Poor health status, huge workloads, inadequate access and restricted access for the prevention funding affects the health care and health care costs to Aberdeen Area and Indian country.

Statistically, a high number of injuries and hospitalizations in the Aberdeen Area require more contract dollars than we have. Reduction of injuries would result in having more dollars available for other CHS needs.

Regardless of the Indian reservation, many tribes share similar concerns and experience the direct correlation between poverty, injury deaths and longevity of life. This testimony will concentrate on the impacts of injuries to children ages 0 to 19. The majority of the injuries are influenced by alcohol, substance abuse, behavioral health and violence.

The Aberdeen Area rate of alcohol-related deaths is 16 times the United States rates. The Aberdeen Area has the fourth largest Native population in the United States, yet the Aberdeen Area has the highest percentage of population below the poverty level. Aberdeen Area has 49.6 percent below the poverty level.

Native Americans life expectancy is lowest compared to all United States Aberdeen Area is 64.8 years. I've got about 2 years left.

The leading cause of death, injuries accounted for 75 percent deaths among young youth between the ages of 1–19 years old between the years 1992–96, as compared to 64 percent nationally. Fire is another accident. In 1993 Spirit Lake Service Area had two fires within a 3-month period that took the lives of 11 tribal members ranging in age from 10–62. Aberdeen Area ranks first in the Nation's IHS area with loss of life to fire and burn-related deaths for ages 0–19, 9.92 percent from 1985–96.

Suicide; from 1993–97 37 Spirit Lake youth ages 5–20 years old made a decision that death was a preferred option over life. Seven completed their attempt in a 10-month period. There was an occurrence of 48 adult suicide attempts over that same period of time. Aberdeen Area ranked second in the Nation's suicide attempts between 0–19.

Native American motor vehicle deaths; 10 percent of the Aberdeen Area cost of catastrophic care is spent on injuries resulting in

Injury is the leading cause of death for ages 1–44. In 1999 Spirit Lake—three Spirit Lake children ages 3, 16, and 19 lost their lives in a head-on collision. Both vehicles contained members of the same family on their way to a family birthday. The potential years of life lost for future generations of their family and our tribe is 62 years, 49 years, and 46 years, a total of 47 years—147 years that were lost.

Aberdeen Area has the highest rate of years of potential life lost, 2.4 times the United States rate. In comparison, the American Indian communities have high youth population versus non-Native Americans, which has a large elderly population.

We recommend that a section 716 be added to the act addressing injury prevention programming:

Develop prevention and intervention models for injury prevention services and needs.

That such funding be appropriated as may be necessary to fund injury prevention services at the service unit level as a line item program.

Add injury and prevention as a priority for Indian Health Profession Scholarships.

Provide scholarships for higher education and in-school training at the local tribal college level for injury prevention specialists and technicians.

As on other Aberdeen Area reservations, the staffing for mental health does not meet the needs. With 5,500 people residing on my reservation, over half being under the age of 18, we have one mental health worker.

We recommend a separate Childhood Injury Act or initiative to prevent injury and save the lives of our children.

There were over 800 treaties between the United States and Indian tribes with fewer than 350 ratified by Congress. On March 2, 1871, Congress repealed the acceptance of further treaties. The number of tribes recognized has increased to over 520. Annually, more tribes seek Federal recognition, yet Federal appropriations remain based on the original treaties, not accounting for the increase of 170 tribes and their population.

Senators and committee members, it is imperative that as you contemplate a decision on S. 2526 you keep in mind our children yet to come. Acknowledge the true reality of the health care needs, the system weaknesses, the neglected voids and the unequal quality of health care access in Indian country.

As leaders of two nations we must respect the history we have both passed through and the history we are making today.

Thank you, Senators.

[Prepared statement of Mr. Longie appears in appendix.]

Senator DORGAN. Chairman Longie, thank you very much.

Ms. Painte.

STATEMENT OF DEBORAH PAINTE, DIRECTOR, SACRED CHILD PROGRAM, UNITED TRIBES TECHNICAL COLLEGE, BISMARCK, ND

peat my name. It's Deborah Painte, Prairie Rose Woman, and I'm a member of the Three Affiliated Tribes, the Mandan, Hidatsa, and Arikara, of the Fort Berthold Indian Reservation. I am here on behalf of the United Tribes Technical College Sacred Child Project.

United Tribes was developed, implemented and created a vocational educational program for Native American students back in 1969. It has evolved into much more than that. It has assisted not only individual students, but it has helped Indian country, as well as the tribes here in North Dakota, to help develop their social and economic infrastructures.

I'm going to digress from my written statement as I know you will be able to read some of the more detailed points of my statement as well as some of the statistics. What I do want to talk about today is the children of North Dakota and what we have been able to do for our sacred little beings. In the Lakota language they call them "wakan yeja," which translates as sacred ones or sacred beings and for us I've been working in this field for over 10 years, and all of the statistics that have been pointed out, as well as those presented by Chairman Longie, are all of the factors that have led to the crisis situation that our children are in.

As you are well aware, there have been many suicide attempts and completions on our reservations in North Dakota. We are also over represented in many of our most restricted facilities in North Dakota, the Youth Correctional Center, state adolescent psychiatric units, substance abuse treatment centers, group homes, foster care homes. It's so numerous to go on, but what I'm here today to do is to share with you a new model of bringing mental health services to children.

In 1997 the tribes of North Dakota through the United Tribes Technical College was funded by the Center for Mental Health Services to develop and implement a new system of care for our Indian children. My remarks are going to be in regard to some of the concepts of that system of care.

When we talk about a system of care, a system of care means that all of the independent systems that are on or near a reservation or within a community come together to the same table to provide planning for these children. That means that we have had to visit with the tribes, we have visited with their local reservation service providers. Without their participation and their leadership and their active involvement, we would not be where we are today.

Currently we have tribal staff, Indian Health Service staff, Bureau of Indian Affairs staff from law enforcement, the tribal courts, mental health, education, child welfare and domestic violence, substance abuse, among others, who come to the table to provide joint planning for these complex needs children.

Many of our children are faced with all of the negative factors that occur on the reservations: Lack of housing, substance abuse, maybe they are from low-income homes. In fact, a significant number are from low-income homes. A lot of our children that we work with are from single-parent families. More often than not these children—their behavior has become so out of control that a lot of

overrepresented in the juvenile justice system. That also holds true for our youth here in North Dakota.

When we first started this, we had to really look at what was creating that phenomena to occur, and one of the things that we found out is there is a lack of community based services for our youth, in addition to the clinical supports that are provided through Indian Health Service. So what we've done under our system of care, and this is what I hope and urge you to strongly consider in this S. 2526, the system of care philosophy, rather than just looking at mental health and education and juvenile justice, child welfare, all of the players need to be at the table when you plan for these complex needs children.

I also want to implore you that we really look at how services are provided and not only to look at the clinical services but the strengths of our communities. That's one of the things that we had to do. We had to start from where our communities were, and what are the strengths of our communities and the strengths of our families. A lot of it is our natural support systems, it's our culture, our spirituality, it's our families, it's our peers, it's our friends.

So what we did under a system of care is we bring all of those professional service providers with the family, with the extended family and the natural support systems. We've come up with unique plans for our children. All of the children that we serve have a serious emotional challenges, and when you look at the juvenile justice system, we're talking about co-occurring disorders, meaning they might have a mental illness, they also have substance abuse issues. There's just a whole gamut of negative factors in their lives that have resulted in them being where they are today.

What we've done with these youth—not only do we provide the clinical support through IHS and BIA funded social services and child welfare, we bring the community into the healing process.

There are two services that we have found that are not included in the legislation—that have been extremely helpful with our youth that we are working with. Those are respite care for families. Because of the pressures of working with a child who has behavioral and emotional problems become sometimes so frustrating and burdensome to them that they give up on the child as well as the service providers, and what happens is they send them away to long-term placements. You, yourself, know that we have many of our kids in boarding schools and many in out-of-home and out-of-State placements.

We have tried to keep many of our kids home, and in fact we have had phenomenal success. To this day we have probably kept 97 percent of those children from being placed out of the home because of the—unique way that we're working with them. A lot of these children are also depressed, have suicidal ideation. We have not had one suicide among the children we are working with, and the reason why is another one of the services and support that is also not listed under this Act is the use of mentorship.

It doesn't cost a lot to bring a mentor, a caring adult or young

families—many of them have become so disempowered that they don't know how to help themselves. Even when they come to us we take a strength-based approach. We don't focus on the deficits We focus on what's going right with the family and what is the strength with the child. It is through those strengths that we have been able to develop solutions that maybe would have not been developed under a normal mental health system.

The plans of care that we have developed are very unique. They are a mixture of professional clinical support, as well as unique community-based programming that have been provided by our own community members.

In the fall of last year we came to you and we visited your office I know, Senator Conrad, we briefly met with you, and we brought a young man with us. He has been written about in a couple of journals already through the Center for Mental Health Services This young man was suicidal, he had assaultive behavior, there was domestic violence in his home, there was multi-generational alcoholism within the home, and——

Senator CONRAD. Deborah, if I could just ask you, if you could just hold the microphone a little further away, you'll get less feedback.

Ms. PAINTE. Okay. He had also dropped out of school at the age of 14 years old. He was dealing drugs, he carried weapons. Eventually what happened within the household, his mother was involved with a drug dealer on one of the reservations. What finally resulted in him coming to the Sacred Child Project was he was stabbed, his mother was stabbed. When we talked to him, he had no hope, and many of these youth—his story is not unique. He had no hope. His family had no hope for him. He was heading to prison, if not death

That young man visited your office. I am yet emotional about this because there are so many youth like that. That young man today has hope. In the 3 years that we have worked with him, he has hope, and a large part of it is due to the people within his community who gave him support, and it was culturally and spiritually based in addition to some of the mental health supports.

The other approach that we take is we help the entire family. We know that we send them to placement for treatment whether it's substance abuse or mental health services, and when they return home, what was happening is within a few weeks, and in some cases that same day, they would return and those behaviors manifested themselves again.

You have to develop community-based services and supports beyond clinical services. Don't get me wrong, we need more clinical services, but this legislation also needs to look at those natural supports. I just want to say one last thing. I know my 5 minutes is up. This young man has completed his GED. He has a vision for the future. He has employment. His goal now is—and he does play basketball, but he never got to play in high school because he dropped out. He's looking at coming to United Tribes Technical College. Three years ago today he did not have a vision for his future, and that's why he had gotten so involved in all those negative be-

cause the system of care has worked, and it's not because of what we've done, but it's because of the system of care model that allows tribal communities to use their own natural strengths to help their families, and with that I'd like to thank you, and I will be available for more information.

We also do our own evaluation, we also collect data. We have a number of comments that relate to the training and the management information system as well the research.

So with that, thank you for your time.

Senator CONRAD. Deborah, thank you very much for that testimony, and I remember very well your coming to my office. It really made a profound impression on me because here was a young person that had no hope, that had no future, and through a community effort you were able to help him understand there was a future, there was hope, and it's really remarkable the turnaround that you were able to achieve in the life of that one young person. That tells me there are lots of opportunities here to help turn around people's lives if there is intervention—if there are adults who can reach into that young person's life and show them that there is a way that leads to a brighter future, and I really want to commend you and the people that work with you because I think you've shown a model of what can work.

So often we focus on the things that don't work and we focus on the failures and we focus on the things that seem to lead nowhere. I think you've given us a pattern and shown us the way that can make a big difference in people's lives. So thank you very much for what you've done. I know it's emotional and in many ways it's traumatic to see people suffering so acutely that they think the solution is to take their own life. That's a tragedy, and we all have a responsibility to stop it.

Thank you very much.

[Prepared statement of Ms. Painte appears in appendix.]

Senator DORGAN. Deborah, thank you for sharing with us today, and thanks for the work you do every day.

Next we'd like to introduce Everette Enno, the chairman of the Aberdeen Area Tribal Chairmen's Health Board. He's also chairman of the——

Mr. ENNO. God's country.

Senator DORGAN. Yes; thank you. Chairman of everything. More seriously, Everette is also the chairman of the Trenton Service Area. As we ask Everette to testify, I think this is a good time to say there are other tribal chairmen in the room, and I'd like to just ask them to stand. Tex Hall, chairman of the Three Affiliated Tribes. Tex, would you stand? Thank you for being here. Richard LaFromboise, chairman of the Turtle Mountain Band of Chippewa. Charlie Murphy has already welcomed us today, and we also have the director of the Indian Health Service in the Aberdeen Area, Bruce Bad Moccasin, are you here? Thank you very much.

Now, Chairman Enno, would you proceed.

STATEMENT OF EVERETTE L. ENNO, CHAIRMAN, ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD, TRENTON, ND

Mr. ENNO. Thank you. Good morning, Senator Dorgan, Senato Conrad, members of the committee. Special thanks to Mr. Gipp fo the hospitality for providing this hearing. Thank you.

My name is Everette L. Enno, and I'm chairman of the Aberdee Area Tribal Chairmen's Health Board and the Trenton India Service Area. The Indian Health Care Improvement Act in its draf form is being proposed for a period of 12 years. The proposed bil is one of the most comprehensive to date for the health care of In dian people. It is very important that Congress understands th issues, concerns and complexities of the Aberdeen Area Tribe when discussing and including the recommendations that will be come part of the final legislation.

The Aberdeen Area Tribal Chairmen's Health Board is comprise of 17 tribes, a tribal health board, and a tribal organization. All o the tribes and tribal organizations in the Aberdeen Area, except fo two tribes, provide health care services directly or through con tracting. The total user population of the Aberdeen Area Tribes i approximately 113,000 tribal members. All of the tribes within th Aberdeen Area continue to receive services through the previou negotiation of treaties with the U.S. Government.

The draft bill in its present form is an excellent document an very comprehensive in nature. There are some health care issue and concerns of the Aberdeen Area Tribes, however, that I fee need to be discussed and incorporated into the final version of th Indian Health Care Improvement Act. The testimony I am abou to present focuses on those health care issues.

One of the most important, Senator Dorgan and Senator Conrad is health care status. The Aberdeen Area Tribes, by and large, hav the worst health status of all areas when all of the chronic illnesse are taken into consideration. Whenever there is distribution out t the tribes, health status is not a factor.

Senator DORGAN. Excuse me. If I could have your attention, really want to give Mr. Enno the opportunity to be heard withou noise in the room. Thank you very much.

Mr. ENNO. It would only seem reasonable and prudent that mor health care funds be distributed to those areas that have the lowes health care status. It has always been known and understood tha the mission statement of Indian Health Service is to provide th quantity and quality of health care services which will permit th health status of Indians to be raised to the highest possible level That has never happened.

A level of need funded study, which was completed in Decembe 1999, is an excellent base for determining the distribution of funds for all tribes. In the final analysis, however, the study does no properly factor in health status, wrap-around services, distance an isolation, et cetera. If the level of need funded study is going to b used as a document for the national distribution of funds, then i needs to be revised to serve its intended purpose, that is, to allo cate funds on the basis of ensuring an adequate level of health car

the Aberdeen Area receives approximately $42 million in contract health service funding. There is a need at this moment for at least $100 million, resulting in an unmet need of $60 million, and this is just for the Aberdeen Area alone.

Another area that needs to be addressed is the Catastrophic Health Emergency Fund. The Aberdeen Area would like to see the threshold reduced by 50 percent from $20,100 to $10,000 and still allow the area office to administer and allocate the funding to the tribes. In the Aberdeen Area alone as of July 1, CHEF cases for fiscal year 2000 totaled $2.2 million. The reimbursement on those CHEF cases back to the tribes totaled $960,000, and that's only from July 1, not counting the other 3 months left yet in the remainder of the fiscal year.

An important initiative that was started a few years ago that needs to be supported and continued by Congress is Healthy Start. Healthy Start has made a positive impact in the Aberdeen Area by reducing the rate of infant mortality by almost 50 percent. For continuity purposes, the Aberdeen Area Tribes would like to see Healthy Start as a permanent funded line item under the Maternal Child Program of the Indian Health Service and not under the state as block grants.

An important part of this draft legislation that also needs to be considered is the process of negotiated rulemaking. As a means of addressing the possible amendments, the Aberdeen Area tribes would like to see the negotiated rulemaking process become a part of the final legislation. This process would ensure tribal consultation and participation from all forms of health care delivery on each and every amendment. This is something that never happened in the past.

In closing, Senator Dorgan, Senator Conrad and other committee members, the Aberdeen Area tribes, as well as many tribes across this great nation, continue to provide health care services to our Indian people comparable to a third-world country. In an era of current and projected budget surpluses, this is totally unacceptable for our Indian people.

Our Indian people negotiated treaties, ceded millions of acres of land and natural resources, fought and gave their lives for this great nation all in good faith. From one sovereign nation to another, it is time for the U.S. Government to acknowledge and address the trust responsibility it has towards the Indian people of this great country.

Thank you.

[Prepared statement of Mr. Enno appears in appendix.]

Senator CONRAD. Thank you very much, Everette. We appreciate that testimony very much. As always, you're right on point. I had a chance to review your testimony before you presented it.

I think at breakfast this morning you made clear the disparity that we're seeing between our part of the country and other parts of the country. Funds that ought to be shared more equally going to frankly less needy parts of the country. We don't want to see them funded at a lower level, but we do want to see

Senator Dorgan and I discussed this morning asking for a GAC evaluation of how the funds are spread because we believe it is not done in a way that is fair.

So thank you again for what you've done to bring this to the attention of the committee. Next, we're going to hear from Floyd Decoteau, who is here representing Chairman Andrew Grey of the Sisseton-Wahpeton Tribe. Chairman Grey, we regret to say, is receiving medical treatment, and we hope and pray that he will have a full recovery.

Welcome, Floyd.

STATEMENT OF FLOYD DECOTEAU, ON BEHALF OF ANDREW GREY, CHAIRMAN, SISSETON-WAHPETON SIOUX TRIBE, AGENCY VILLAGE, SD

Mr. DECOTEAU. Thank you, Senator Dorgan, Senator Conrad, and members of the committee, for this opportunity to testify on the reauthorization of the Indian Health Care Improvement Act. I will highlight the major points of Chairman Grey's written statement that you have before you.

Quality of life can be measured in two statistics, infant mortality and life expectancy, noted on page 1. On page 7, the written testimony provides a more comprehensive comparison of the behavioral related health status indicators. Consistently, the Aberdeen Area statistics are the worst.

Deplorable health statistics and social problems are all symptoms of the underlying behavior dysfunction that approaches. The approach outlined in section VII is imperative for effectively addressing the afflictions of the body, mind and spirit that manifest themselves in the dramatic health status disparities between the first Americans and the general population of this nation.

The core benefits package that the Indian health system is typically able to offer is admittedly inadequate given the severe limitations of appropriations, staff and facilities. Title VII provides several excellent and innovative funding authorities which, if enacted, could potentially eliminate the health disparities for Indian people.

There is a need for more behavioral health research in Indian country as provided in section 713. Our written testimony discusses in detail several research projects, about lifestyle and the effect of quality of life noted on pages 4, 5, 6, and 8.

The Sisseton Indian Health Service carried over a $200,000-deficit in its contract health budget. That had to be taken off the current year's allowance.

During the first 8 months of this fiscal year, the Sisseton Indian Health Services deferred 462 cases. Things deferred were eye care, orthopedics, cardiology, physical therapy, ENT, neurology, gynecology, urology, and et cetera. The estimated cost is $407,500.

In view of these considerations, the new and expanded authorities for behavioral health programs provided in S. 2526 are critical. Access to services is inadequate. The Aberdeen Area has only 86 beds for alcohol/substance abuse treatment beds available to serve a user population of 113,064.

I would like to briefly cite the study on the LNF, which does not include wrap-around service. It only provides core medical services.

Behavioral health, holistic treatment of body, mind and spirit, is a wrap-around service. Wrap-around service is not measured by the LNF study. Behavioral health requires its own study as authorized in section 701. The MOA described in section 702 provides—should include—should include behavioral health programs funded by other agencies within HHS. This authority is necessary to expedite and facilitate interagency cooperation, referrals, and individual case collaboration in the prevention and management of behavioral health risks and problems. Whichever agency has funds—funds the program, they must be able to work together to share specific information in order to be effective.

The sheer magnitude of disparities in life expectancy and infant mortality rates between the first Americans and all other Americans justifies the need for a new authority in this reauthorization bill. We seek your assistance and support in securing passage of this important Indian health legislation as soon as possible.

It is a privilege to testify before you today.

[Prepared statement of Mr. Grey, as presented by Mr. Decoteau, appears in appendix.]

Senator CONRAD. Thank you, Floyd.

Senator Dorgan will introduce the next witness.

Senator DORGAN. Our next witness is Anita Whipple, who is the tribal health director of the Rosebud Sioux Tribe.

STATEMENT OF ANITA WHIPPLE, TRIBAL HEALTH DIRECTOR, ROSEBUD SIOUX TRIBE, ROSEBUD, SD

Ms. WHIPPLE. Good morning, Senators and Honorable Chairmen. I want to thank you for this opportunity to present a statement on the proposed amendments to the Indian Health Care Improvement Act.

The first thing I'd like to talk about would be——

Senator CONRAD. Anita, if you'll just hold the microphone down—these microphones are so sensitive. If you have them too close, you get a lot of feedback.

Ms. WHIPPLE. Okay. Due to cultural differences there are many misunderstandings to meanings and definitions of words. One of those words is "entitlement." In the non–Indian world, entitlement means a contributory program whereas individuals have contributed over a period a time to a fund and earned the benefits of a program, such as Medicare and Social Security.

In the Indian world, however, entitlement means something entirely different. We view entitlement as an unpaid, outstanding bill where loss is incurred, loss of economic status, loss of land, loss of culture, as well as punitive damages for historical grief and loss of trust responsibility.

We carry this grief today as we hear about budget surpluses and see our health care dollars shrinking and going down. This is a very emotional issue for Indian people. We are all familiar with the

Under the differences of definition, tribes are not asking for more than their fair share, and they are not asking for anything for free Tribes are requesting a fair, justifiable stable payment for losses incurred as demonstrated by those two charts on the wall. If dollar figures were put to those figures, we feel we have health care prepaid and it has been prepaid for a long time.

Congress must bring health care disparity and continual shortfalls compounded with a growing unmet need into equity with mainstream health care services by creating permanent appropriations legislation. The Aberdeen Tribes request that health care funding for Indian people become an entitlement program.

We do not believe that eligibility or tribal resources have any involvement for entitlement. Entitlement means, like I said, a prepaid health care plan due to losses already incurred. Due to the length of this bad debt, you can see the continued disparity and growing poor health status. We cannot leave the health care for America's first citizens in the president's discretionary budget. It must become permanent authorization authorized by Congress as part of its treaty obligations.

In recent testimony Commissioner Callahan has stated the Indian Health Care Improvement Act is too costly section by section by section by section. Is it too costly? If you compare it to the graphs, I don't think it's costly at all, and I'm sure the tribes will agree. If it continues to go on a downhill slope where we are required to be under priority one only, then you talk costly. Then you talk damages to life and culture, a culture that is based on this land, this land that we all share. I'm a combat vet out of the Vietnam era. To come home and to have to face this kind of disparity really hurts.

More importantly, what I need to talk about is emergency medical services. There is no current authorization for emergency medical services. In 1966 the Highway Improvement Act established the EMS under the Department of Transportation. It has never had medical funding of any type.

In 1990 Congress put in the Trauma Care and Development Act, and in 1995 it did not reauthorize that act. There is no current legislation for emergency medical care. Every citizen in the United States lives in a state of denial. We are never going to be the ones in the accident or needing an ambulance. You're never going to know when you're going to need that. Statistics from the Department of Highway-Safety prove that at least every person in the United States needs emergency medical services at least once in a 7-year period. Without authorization for EMS, States, counties, municipalities, and especially Indian Health Service, is having a difficult time in funding emergency medical services.

In 1973 the EMSS Act was put in place and it identified 15 costly components to make a complete system. Those components include medical direction, communications and trained personnel. With technology and training, people are demanding better, faster services. There is no money for EMS. Tribes within the Aberdeen

My tribe alone has over 428 critical calls per month. It is the highest in the State of South Dakota for call rate and volume. A lot of these are alcohol and substance-abuse related.

I can say nothing more but to please evaluate how Congress funds EMS, especially in Indian country where isolation, inclement weather and distance are a major factor. You never know when you're going to need an ambulance for a heart attack, a disaster, a motor vehicle accident.

When I talk of those things and I talk of motor vehicle accidents that have left people totally disabled and rearranged their lifestyle, when I talk about heart attack where you need lifestyle modification, when I talk about diabetes, people in comas that need ambulance care, I am also saying that these people need mental health services. If you're a diabetic facing an amputation, you have various levels of depression in that aggression. If you are in postpartum depression that's continued, you need mental health care or behavioral health care. If you're an undernourished elder, you need health modification.

I am suggesting that we have a team approach to all health care patients, where every patient is at least offered behavioral health consultation and modification through education.

Thank you for your time.

[Prepared statement of Ms. Whipple appears in appendix.]

Senator DORGAN. Anita, thank you very much.

Next, we will hear from Marlene Krein, who is the president of Mercy Hospital in Devils Lake.

Marlene, thank you for being with us today.

STATEMENT OF MARLENE KREIN, PRESIDENT, MERCY HOSPITAL, DEVILS LAKE, ND

Ms. KREIN. Thank you, Senator Dorgan and Senator Conrad, for the opportunity to provide testimony today regarding S. 2526. Mercy Hospital is a faith-based organization, and our values speak for human life and community service.

Mercy Hospital's service area is located in a rural agricultural community with a primary service population of approximately 15,000. The southern boundary of our service area encompasses the Spirit Lake Nation, a community of approximately 2,500 Native Americans.

The plight of the American Midwest is a story that does not command front-page attention. The story theme has become an all too familiar saga. Small towns are becoming ghost towns, and the inability of the rural community to attract and support industrial and technical business has resulted in a lack of good paying jobs.

Inland flooding that is unmatched for most of our history fails to attract attention if it is in a rural, sparsely populated area such as Devils Lake. We are in our seventh year of flooding with a landlocked lake that has risen over 25 feet and has flooded thousands of acres of productive farmland.

In spite of the many obstacles faced here, Devils Lake has an above-average opportunity to meet most primary and secondary

pital is the only source of after-hours care within our primary service area, and in spite of the inability to collect for much of the health care provided to the people of the Spirit Lake Nation, we continue to serve them.

Indian health contract services are not adequately funded at our local service unit. We, as a small rural provider, are disproportionately impacted by this lack of funding for provision of services that are clearly a Federal obligation. Medicaid volume at Mercy Hospital qualifies the hospital as one of two disproportionate share hospitals in the State of North Dakota. We have an extremely busy emergency room but are unable to cover the cost due to a high percentage of Medicaid volume and uncompensated Indian health visits.

Indian Health Service refuses to recognize after-hours emergency care for payment, except life-threatening conditions. Services to Native Americans in our emergency room account for at least 40 percent of our total outpatient emergency room volume. North Dakota Medicaid pays for 65 percent of this volume. The remaining volume is potentially funded or rejected by IHS as self-pay or indigent care. In addition, funding for other acute services provided is always inadequate.

In the case of obstetric care, of which our payor mix is 50 percent Medicaid, Mercy Hospital is forced to subsidize service to this population in excess of $150,000 a year. Often there is no payment for this care when Indian Health says the mother failed to apply for Medicaid. Payment is also denied for children under age 18 when IHS believes they are eligible for CHIPS.

Our request that IHS pay their fair share for resources consumed has become increasingly important as payers set rates at dangerously low levels. Blue Cross of North Dakota, a dominant commercial payer within our state, has implemented draconian reductions in fee schedules within the last 2 years. In addition, Medicare has passed outpatient PPS, and Medicaid will soon follow. With the rules and regulations of today, there is no means to fix the current problem.

The unwillingness of IHS to reimburse Mercy Hospital for services rendered affects not only the operations of the hospital but also the entire staff and community. The nonpayment of these accounts can no longer be borne by the community at large. Last year, staff at Mercy Hospital did not receive salary increases due in part because of IHS payment uncertainty.

The staff time required to process the IHS claims is quite disproportionate to the number served. The fluctuations in accounts receivable have led to numerous meetings with the local IHS, congressional delegation, the tribal board and tribal chair. There is a spirit of collaboration between these agencies, but Government guidelines for this program have made it impossible to find a lasting solution to the most basic business principle, reimbursement for services rendered.

I support reauthorization of this bill, but ask for appropriate

I remember a few years ago when Senator Conrad asked me at what point Mercy Hospital would be unable to serve with the lack of reimbursement. My answer at that time was I would find a way. Actually, at that time I told him I'd do a couple of bake sales. Today my answer is we are dangerously close to having to reduce or eliminate services. My responsibility is to serve the entire community and do whatever I can to ensure that Mercy Hospital remains viable. It is imperative that IHS reimburse adequately for services rendered if we are to fulfill our commitment to the individuals and the communities we serve.

Thank you.

[Prepared statement of Ms. Krein appears in appendix.]

Senator CONRAD. Thank you, Marlene. Senator Dorgan and I were just looking over the table that you provided us in terms of uncompensated balances at the hospital, which are now anticipated at nearly $900,000. For a regional medical facility, that's just a crushing burden. Over and over we have gone to the IHS, as you know.

Most recently, Senator Dorgan has interceded to get that paid down, but this is an ongoing problem and really a crisis, and I don't think this legislation actually will solve this problem. It will perhaps help, but I think we probably need to introduce separate legislation that would address directly the unique situation of Mercy Hospital because as we've discussed many times in the past, you're really in an unusual situation, and it's falling through the cracks, and this shouldn't be acceptable. As many times as we've tried to intercede with the IHS, as many times as we've gotten it paid down, the problem never gets solved. So we've got to find a better way.

Next, we'll hear from Dr. Biron Baker, who is a tribal physician from New Town.

Welcome, Dr. Baker.

STATEMENT OF BIRON BAKER, M.D., TRIBAL PHYSICIAN, MINNE TOHE HEALTH CENTER, NEW TOWN, ND

Dr. BAKER. Thank you, and good morning, Senators, and good morning to everyone present. The item that I've been asked to speak about involves prescription drugs and our patients' access to those prescription drugs.

Prescription drugs are the current hot item in health care today. Whenever people debate the cost of health care and the rising costs of health care, drugs inevitably come up because of their costs. Anyone can quote—anyone who's been to a doctor recently can quote how much they paid for their medications. It almost becomes a hot topic of conversation wherever you go.

This is true also for IHS patients, but it's got a bit of a different twist to it. It seems that as physicians involved in IHS, I'm currently a tribal employee working in an IHS facility, and I think that's kind of a unique situation currently in the Aberdeen Area, but either way, be I a tribal employee or IHS employee, we're in

always asking about the latest drug and when are we going to get it and why don't we have it.

We start with explaining in terms of funds and we generally finish explaining in terms of funds, and that's always a frustrating answer to give your patient who asks you why can't he have this heart pill that's going to take care of all his chest pain.

Our budget at the Fort Berthold service unit has currently expended more than the $800,000 in terms of purchasing drugs, and we were budgeted for about one-half that amount. So we're overspending. By the end of the fiscal year, we will have expended over $1 million.

The recurring budget at Fort Berthold has not exceeded at any time $500,000, but costs continue to rise. Our prime vendor is Amerisource, and we are able to purchase drugs from them at considerably less cost than we would if we had to buy them from the private sector, but the costs are continuing to outpace the budget.

The number of prescriptions filled at Fort Berthold continues to rise. In 1996 there were 39,000 or so. The projected number for 2000 is around 80,000 prescriptions filled. So the access to medications will soon be a bigger issue if we are forced to limit patient services. We don't want to do that, but we think it's an inevitability.

Patients also have a perception that a lot of drugs aren't available. We do have some of the latest drugs for arthritis, diabetes, cardiovascular diseases and other conditions as well. Most of these medications are not generic as some patients tend to believe. In the IHS formularies the medications sometimes come out with the generic name of a medication rather than the prescription brand name. So Prilosec becomes omeprazole, and all of a sudden there is a substandard medication although it is same medication, and the reasons for that kind of perception go way beyond the scope of what I'm supposed to tell you today, but——

Senator CONRAD. But, Dr. Baker, is it a purple pill still?

Dr. BAKER. Right. Still a purple pill. And what happens when you change to the pink and black pill? Now people believe that Prevacid, or lansoprazole, is something inferior for Prilosec, or omeprazole, and try explaining that one to someone who is convinced that only Prilosec will help.

These perceptions are something that we can work with through patient education, but the cost is just phenomenal. We have them because they're necessary. We can't ignore patients that need treatment for this because either we pay on the front end or we pay on the back end when someone ends up with a Barrett's esophagus or adenocarcinoma and it has to all be resected and then you've got a feeding tube, and on and on and on. I think that kind of speaks for itself.

Some of our medications are what we call non-formulary, which means we have that but officially we don't have them, and some patients get them and some patients don't. Typically these are our sickest patients. Let's say, for instance, I send a patient to see the cardiologist and he recommends a certain medication. Do I then ig-

ommended? In many cases, I ask the cardiologist, is there another way we can do this? No, you need this medication. So if we ignore the recommendations of our consultants, it would seem unwise to even seek their advice.

If patients had to purchase these medications for themselves, their costs would even be greater, and I know this is something that's debated at the national level currently with what the older population is paying for prescription drugs. I put together a small list of medications, a 1 month's supply of these medications, and what I would consider to be an average cost to the patient. The medications are Metformin, which is a diabetes medication; Avandia, another diabetes medication. Sometimes they use a combination of Metformin and Avandia. Prevacid, the aforementioned pink and black capsule; Lipitor for high cholesterol conditions; Celebrex for arthritis. We have some horrible arthritis in some of our folks. Norvasc, which is a cardiovascular drug and antihypertensive.

Metformin, 60 tablets, is $41.95. Avandia, 8 milligram tablets, $125. Prevacid or Prevacid, depending on how you want to pronounce it, that's $106; Lipitor, $84; Celebrex, $132; and Norvasc comes in dead last at $41.

As these costs continue to rise and as our budget continues to remain the same, we're going to have more problems. It's going to get worse. Patients won't be able to obtain medications because we simply won't be able to procure them. We'll be forced to make some unfair choices, and I, for one, don't want to be in that situation. I know that most physicians would not be. If we were all of a sudden told that three out of five of our diabetic patients can get treated with the latest drug, I don't want to be the one that has to pick three and ignore two others.

As a group, I think most of the IHS physicians that I've worked with in the past have been pretty responsible. When choosing medications for our patients, we always try and use the older medications whenever we can. We try to follow formulary guidelines. At the risk of sounding simplistic, we need more money, and I don't think anything else is going to fix this. I can say that my experience at Fort Berthold and my experience with Commander Ernie Scott in Fort Yates have been pretty similar.

Thanks for your time.

[Prepared statement of Dr. Baker appears in appendix.]

Senator CONRAD. Thank you very much, Dr. Baker.

We're next going to hear from Commander Ernie Scott, Public Health Service pharmacist at Fort Yates, ND.

STATEMENT OF CDR ERNEST R. SCOTT, CHIEF PHARMACIST, FORT YATES PUBLIC HEALTH SERVICE HOSPITAL, FORT YATES, ND

Mr. SCOTT. Good morning, Senator Dorgan and Senator Conrad. I'm probably just going to reiterate what Dr. Biron Baker just said.

One of the most problematic things that is of concern to our patients is access to formulary medications, prescription drugs. Al-

and it's comprised of medications that have been diligently researched by pharmacy and therapeutics committees and the medical staff. It's researched with the—based on safety, efficacy, drug cost and the prescribed practices in the community.

The importance of this can't be overstated when you look at the figures that have already been mentioned. Around the United States there are 1.3 million IHS total users, and in the Aberdeen Area there are about 113,000, so one could use these figures to determine approximately what amount of the total money given to IHS should be given to the Aberdeen Area.

Senator CONRAD. Could you repeat those?

Mr. SCOTT. It's been reported by members here earlier that across the United States there are 1.3 million users, IHS users. In the Aberdeen Area alone there are 113,000 users, and I'm not telling you to do this, but this just could be used as a benchmark to see how much the Aberdeen Area may get from the total money given to all Indian Health Service. That's just a benchmark.

Another problem is recruitment and retention. I can only state for pharmacy, but it may well be for other disciplines. Pharmacy personnel play an equal part in the development and management of the formulary, but right now there is a 20 percent shortage of pharmacists in the Aberdeen Area. 45 percent of these have been short for longer than 6 months.

Salaries for Indian Health Service pharmacists are much lower than the outside world, the private sector, and that makes it a lot more difficult to recruit and retain personnel, and that's also another problem for the patients. It presents a problem and a disservice to our patients when we are unable to provide the services and personnel that are needed.

Thank you.

[Prepared statement of Mr. Scott appears in appendix.]

Senator CONRAD. Could you tell us what—if we've got 113,000 out of 1.3 million, that would be something under 10 percent——

Mr. SCOTT. Yes.

Senator CONRAD. Which is what we could fairly anticipate receiving. Do you have any idea what percentage we do receive?

Mr. SCOTT. No; I don't. I don't know a figure.

Senator CONRAD. I think we all know, though, that it's going to be substantially less than——

Mr. SCOTT. That's true.

Senator CONRAD. That benchmark would lead us to conclude is the appropriate amount. Is that fair to say?

Mr. SCOTT. That's fair to say. Yes.

Senator CONRAD. Would it be—would you question it if I said we're probably less than half of what that benchmark is?

Mr. SCOTT. I would not question it. I have not been given the figures, and I would have to ask my superiors before I could even comment on this.

Senator CONRAD. Well, I would like to ask you to provide for the record for this hearing a specific calculation of what the Aberdeen

Senator CONRAD. I think that is very important to the record of this hearing, that we know precisely what percentage of the overall funding the Aberdeen Area currently receives compared to the population that we serve in relationship to the entire population that is eligible. Could you do that for us?

Mr. SCOTT. I've just been given a note here that Mr. Bad Moccasin is in the back of the room, and he may have these figures at hand.

Senator DORGAN. Let's ask Mr. Bad Moccasin if he can provide the information on the question that is asked. Would you provide him a microphone.

Mr. BAD MOCCASIN. I guess I have to clarify, first of all, whether we're talking strictly prescription or we're talking about overall appropriations?

Senator DORGAN. Both.

Mr. BAD MOCCASIN. And I don't have the information about the prescriptions. We spend about—anywhere from about $10 million or $11 million a year in the Aberdeen Area for prescriptions. Overall budgetwise, IHS' budget is about $2.4 billion. Our recurring appropriation in the Aberdeen Area is about $200 million. So I'm not familiar with what we're spending IHS-wise in prescriptions, but I'm sure it's a large number.

Senator CONRAD. If you could get us those numbers, I think it would be very useful——

Mr. BAD MOCCASIN. You bet.

Senator CONRAD [continuing]. For us. Because I think most of us are under the impression that other parts of the country, specifically the Southwest and Alaska, get a disproportionate share of IHS funding. If that's not true, we should know it, but I believe that it is true from previous hearings that I've participated in. That's number 1.

No. 2, with respect to prescription drugs, the same question. And, No. 3, quite apart from the answer to those questions is the difference between what the need is and what is being provided, because we know when you have to be priority one in order to get contract health services and the standard is that you've got to have life-threatening or limb-threatening diseases or illnesses, that's just not a standard we'd apply anywhere else in American life, and it's totally inadequate, and I think all of us who are in the system know that it's inadequate.

I'd ask, Mr. Bad Moccasin, do you believe the resources that are available to you are adequate or woefully inadequate to meet the needs that you are asked to addressed?

Mr. BAD MOCCASIN. Well, as testimony from the folks that are here this morning, it's inadequate. We just don't have enough funds to treat the chronic problems we have in health care in the Aberdeen Area. I mean, statistics haven't changed in all the years I've been with the IHS. I mean, it takes many years to make positive strides in improving the mortality and morbidity rates. Certainly we need more money.

Senator CONRAD. How much of an increase—if I could ask you,

is out there in the Aberdeen Area, how much money do you believe that you would require?

Mr. BAD MOCCASIN. I would say we'd use, on the conservative side, probably four or five times more.

Senator CONRAD. Four or five times more?

Mr. BAD MOCCASIN. Yes.

Senator CONRAD. So you'd be talking $800 million to $1 billion—$800 million to $1 billion instead of the $200 million that you're currently receiving?

Mr. BAD MOCCASIN. That's correct.

Senator DORGAN. Mr. Bad Moccasin, thank you very much. For those who have presented testimony, we have received written testimony and that will be a part of the record, and we also are recording through transcription for the hearing record, as well.

What we would like to do now is—we have some questions as we go along, but for the remaining period of the hearing, Stephanie Mohl has a mobile microphone, and we'd like to have a brief period of open microphone for those who wish to add to the testimony that you've heard. I think the testimony has been excellent. I think this really adds to the hearing record on the health care needs in Indian country, and what I'd like to do is invite others to raise your hand if you have something that you would like to contribute. I would ask that you be brief when you do that, but—I said brief, Chairman LaFromboise. I saw Chairman LaFromboise raising his hand. Why don't we ask Stephanie Mohl to provide a microphone to those of you who do raise your hand, and let's begin with Chairman LaFromboise.

STATEMENT OF RICHARD LAFROMBOISE, CHAIRMAN, TURTLE MOUNTAIN BAND OF CHIPPEWA

Mr. LAFROMBOISE. Thank you very much, Senators and Senator Campbell, who isn't here. We welcome this inquiry out to the Indian country. You know, we're standing right here just north of the place where the last guy that was doing ethnic cleansing said to the U.S. Government, Don't do anything until we come back. And we Indians in this room, all of us related, in the center of the country went out there and took care of him, and that was Mr. Custer, and they ain't done nothing in this country as far as government activities to, quote, complete that agreement that we originally entered into, and that is adequate health care.

I applaud Mr. Bad Moccasin for actually kind of sticking his foot in his mouth a little bit, being conservative, saying five times more, but the reality is something of which we initiated and presented to the president of the United States. Thank you, Senators and delegation of North Dakota, South Dakota, and Montana that I think put that together. I think that those same tribal leaders should probably be able to revisit with the president when he signs this reauthorization of S. 2526.

I also am going to give a copy of that testimony that we in the Aberdeen Area provided to the president when we visited with him.

I would like to be able to be very brief, and I'd like to say after my 18 years of being a tribal leader and trying to find a way of which our people can move forward, is I'd like to be able to put some ideas of "fix" in it rather than trying to keep on telling the terrible stories that we've heard all these time.

You just heard the IHS director of our area say about five times more. He's pretty close to correct. Right now the IHS in a study of 1993 to 1998 shows that IHS provides about $1,400 per Indian in IHS care. The Turtle Mountain Tribe is a little bit better off because we have a hospital and direct care and we're able to do some Medicare/Medicaid. We provide about $2,000 per Indian individual.

The Bureau of Prisons in our area provides $3,500 for an inmate, and that's why I believe maybe at the State Pen out here we're—you know, only 3 percent of the State of North Dakota is Indian, and there's about 25 to 27 percent in inmates over there. They must be going there to get good, adequate health care.

The VA provides $5,500 for individuals and care. The United States population is somewhere around $3,500, pretty close to the Bureau of Prisons, of providing health care to their population throughout the United States. Thanks to IHS and all those people that did some research.

Now, how do we fix this problem? Do we just reauthorize this bill and continue to create these horrific ideas that we have out here and then maybe even try to get some innovative ideas and say, well, is it ten percent of it or not? Well, here's a solution, and I'd recommend this very wholeheartedly to put us on what I would call a mission to correct some things that happened to my people.

I'd like to see the new legislation create the idea that we American Indians are actually pretty much equal to veterans. Why can't we be put on the same status as a VA hospital to do cross-references, cross-hospitalization, cross-cost and equal pay, equal care? Why can't we take a look at our service units having advanced sharing agreements and authority with the VA? Why can't we have our IHS appropriations supplemented? For example, I tried to give the IHS service unit money to hire a physical therapist. The tribe couldn't give them money. They cannot accept money from tribes.

We need the authority to fill and bill non-beneficiaries for prescriptions. For example, that's how a hospital operates, financially, equitably. We need that authority to be able to build and to provide that service in a fair amount of character for us to survive. I'm talking because on behalf of a hospital, we're the only tribe, I believe, represented at the present time that has stepped up here, other than Rosebud, that has a hospital and will give you some direct relationships on how a hospital needs to run, along with Mercy that provides services for Devils Lake also.

Our service units should be able to perform a direct services association to advise tribes of impacts from the self-government tribes and programs. You know, it seems like these self-government tribes—a lot of those guys that I see out there in the East Coast that have all those big casinos and making all that money, that puts a perception out there that we're all casino rich in here.

little program such as Deborah Painte's program and those other real needy and extra wrap-around service concepts that we create in Indian country.

I think that basically the contract support services costs should be renamed the cost of decentralizing. You know, the funding should be set aside for direct service tribes. You know, we're treaty tribes. We're different than a lot of those other guys that, you know, Johnny-come-latelys, and then they add a bunch of roll members on there and you can't even really identify with them. You know, you get the—the picture changes from the old Indian with the tear in his eye sitting there watching America being discovered. You've got—wow, where did they come from, you know. Way down South. But let's not get into that.

Senator CONRAD. Are you questioning the validity of some of these——

Mr. LAFROMBOISE. I'm just saying that the American population has sure tried to deplete our identity. Let's put it that way. The funding——

Senator DORGAN. I'm going to ask you to summarize.

Mr. LAFROMBOISE. Summarize. Okay. This is the biggest problem we have. The direct service tribes—right now we should be based on some kind of a population equity basis. Now, you two senators are from this area so you realize very astutely the two poorest counties in the country are right there, Pine Ridge, SD, and you come up here to Sioux County in North Dakota. Now, in North Dakota there are only two counties that sort of—as a population—and you're very aware of the population outgrowth. There's only two counties that really have grown, Turtle Mountain, which is Rolette County, and I believe the growth in Sioux County, and I believe the growth—like those guys down there at Fort Totten do a good job of it, too, and I see that over in Walsh County they have a growth, but the Indians are growing in North Dakota. We're wanting to stay here. This is where our home is, and, you know, it's sad that we're not getting anybody's ears.

We're getting a lot of "photo ops," as they would say, but we're not getting any ears as to what really is happening. Our direct services to our Indian people out here need to be in an equitable fashion that other Americans have the opportunity to enjoy, and they are enjoying them as Ms. Whipple pointed out, at our expense.

Senator DORGAN. Thank you very much. Chairman Hall.

Mr. HALL. Briefly, thank you, Senator Conrad and Senator Dorgan. Tex Hall, Three Affiliated Tribes, and also Chairman of the Great Plains Tribal Chairmen's Association. I'll be brief and I'll keep it just under 1 minute because I have some tribal members, one who's beside me, Evadne Gillette, who worked for the Indian Health Care Service, but to summarize my comments as I shared with the other chairmen, LaFromboise and Longie, I concur with your points, Senator Dorgan, that health care indeed is a crisis in Indian country. But before I talk about that I just want to let the audience know and commend the two senators here for getting a field hearing out in North Dakota. They are the only Senators

here in being able to do this and let the membership here speak about the importance of health care. So I commend you both, Senator Conrad and Senator Dorgan, for getting this done.

I am one of those dammed Indians. I come from the Fort Berthold Indian Reservation. Because of the Garrison Dam we had a hospital and now we don't, so we depend on contract health care more than ever. We don't have ample authority, and our closest hospital is Minot that our membership goes to, which is 70 miles away, and I'm sad to say many members lost their lives going from New Town to Minot because of these types of situations.

So I'm hoping that we can get the funding for emergency medical that Anita Whipple was talking about. I'm hoping that we can increase contract health care dollars, but more specific, Senators Dorgan and Conrad, I think the formula must change to increase the funds for those parts of the country that need it the most, and right now that's not the case, and so our statistics at Three Affiliated and Aberdeen Area speak for themselves. We have the worst health care statistics in the United States. So I think it's very pivotal that the hearing is held here today.

The other thing I want to talk about is just the—it's kind of in line with Marlene Krein from Mercy Hospital about unpaid medical bills, but before I say that, the statistics, Senator Conrad, about 113,000, we've estimated there's 250,000 members in the Aberdeen Area, and we've also—I think the census will show instead of 1.3 million people, there is 2.5 American Indian people in this country, but it's because of the CHSDA, which is the Contract Health Service Delivery Area, my membership at Fort Berthold are not eligible for contract health in Bismarck here because we're limited to that area, the reservation and the surrounding counties.

We went on record with Chairman Enno and Chairman Longie to pass the resolution in the Aberdeen Area to designate the entire Aberdeen Area as a CHSDA because we have 10 to 15,000 American people living in Bismarck and Mandan that are not—many of them are not getting services because they do not fall into that CHSDA. So the 113,000 population is really low.

My final point is on the unpaid medical bills. That is a crisis that Mrs. Krein is talking about, and one of my elders, Evadne, will testify to that. Many debt collectors are coming and denying services to our members because of the lack of funding that IHS does not have to pay for these bills in a timely manner. We've also passed a resolution at the Aberdeen Area Tribal Chairmen's Health Board to disallow the priority one. That is the worst thing we hate, is priority one status, because, as Senator Conrad had indicated, you have to have life- or limb-threatening in order to qualify, and if you don't, you don't qualify for that.

So that's why cancer is high, diabetes is high and heart disease is high in the Aberdeen Area because we can't get the prevention. We simply don't have the dollars to get the prevention. We get it after the fact, and then we have more people in Rochester now because of cancers, leukemias. This is detected after the fact because we don't have dollars in prevention. That's why our statistics are

STATEMENT OF EVADNE GILLETTE

Ms. GILLETTE. Thank you, Senators, for coming. I'd like to thank you both for coming here from the people here on Fort Berthold, and I will speak fast. In our family, my husband and I raised eight children and helped raise other children, also, and after my children were grown, were all school age, I returned to school. I was an older-than-average student, and I am an LPN and later I got a Master's degree in social work, and I taught at the college and worked for various groups.

In the 1990's I worked for IHS in mental health and was a volunteer social worker for the Indian dialysis program in New Town when it was seeking accreditation. Then later I worked 2 years for the tribe in the dialysis program as a social worker. Finally, I retired and I've been in reservation life problems.

Authorization and lack of payment. The main problems are inadequate funding and staffing for services, and I have attached a list of other problems that need attention. Today I would like to address the problems of authorization for services and lack of payment. Simply, it concerns referrals for off-reservation health care. At Fort Berthold we have only a clinic and do not have a hospital. This means any surgery, and so forth, must take place at area towns such as Bismarck, Minot or in Minnesota.

First, authorization process for Medicare is not clear. My first experience with the referral system began when I was a student in 1970. I was told the area office at Aberdeen, South Dakota, took care of student health care. I followed their instructions, but my medical bills were not paid or paid late. The hospitals turned the bills over to a collection agency. I had to go to Legal Aid to try and get it straightened out.

For 21 years I lived and worked off the reservation. I had no problem when working because I had private insurance. After my husband died in 1987 I returned home—I returned home to the reservation—to the reservation. I had Medicare and was certain they just would honor or pay the 20 percent not covered by Medicare. I just stalled on payments and the collection agencies again hounded me.

Referral and payment process. On February 17, 1998, I was diagnosed with lung cancer. I was referred for off-reservation treatment by a doctor. I thought the referral was for the entire treatment process, but I was mistaken. After chemotherapy and radiation treatment, I was discharged from the hospital and began follow-up care. I was surprised when I received a letter of denial for payment by IHS. This letter stated that I had not received prior authorization from IHS and I could appeal.

I did appeal and was finally approved for payment by an IHS committee, many of whom are not medical people. Does it make sense for someone not trained in health to make life and death decisions? No payment. Though my medical bills were approved for payment by IHS about 3 months ago, I began receiving bills from clinics. I was told that I was to inform the IHS clinic at New Town

The result is I have no credit anymore. IHS did not pay the bills or paid some really late. Meanwhile, my credit was destroyed. This is embarrassing and demeaning. Most elders on fixed incomes—are on fixed income and cannot pay huge medical bills when IHS fails to pay for bills as promised. I happen to know because I received Medicare summaries that one injection I was receiving when I was—for my blood cost $1,500 an injection. No way could I afford that, and I'm not alone in this. There are many others back home who have this problem, and a lot of them are elderly.

The tribal people have paid dearly for whatever services we receive. The tribe has given up land, water and other resources, minerals. There appears to be only one way a person can receive adequate health care, and that is to become a total—totally destitute or poor, then Medicaid will pay, but it also, I think, wipes out your identity. When a person is on welfare, then the welfare system will see that bills are paid.

In closing, I ask you to take a hard look at the problems that Indian people in North Dakota and across the country deal with. The bureaucracy is not responsive to the needs of the people. Legislation is needed for adequate funding and to speed up services, and I thank you for your help on solving the problems in the Indian health care.

Then I have a list here. Problems in IHS care: Lack of a hospital on the Fort Berthold Indian Reservation; lack of experienced doctors; difficulty in securing authorization for medical services, such as off-reservation health care; problems in getting IHS to pay for authorized medical services; credit problems for people due to IHS's failure to pay for authorized services; in emergencies the off-reservation service providers, the hospitals, have to provide health care even in emergencies. This is since IHS is getting notorious for refusing to pay for medical care. The lack of coordination of services; the IHS needs a program for preventive medicine and coordination of other Federal services or funds that are available; lack of a long-range plan. The tribe and IHS must take a serious look at the recurring health problems and do something about it. Everyone knows there are problems but followup is not done. Number nine, the last one, medical care must be made a priority.

Thank you.

Senator DORGAN. Thank you very much. For purposes of the recorder, can we get Mrs. Gillette's first name?

Ms. GILLETTE. Evadne.

Senator DORGAN. Can you spell that for us?

Ms. GILLETTE. E-v-a-d-n-e.

Senator DORGAN. Thank you very much.

Ms. GILLETTE. It's Greek.

Senator DORGAN. It's Greek, you said. Are you related to Austin Gillette?

Ms. GILLETTE. He happens to be my son.

Senator DORGAN. Well, that will not affect your credibility, but he, of course, is a tribal member and a member of the tribal council. Let me say seriously, thank you for telling us your personal cir-

a diagnosis of cancer. You shouldn't have to try to fight cancer and then have to fight with the IHS and bill collectors. You ought to be able to save your strength for your fight against cancer. We need to find a way that people like you are not in a circumstance where your credit is ruined and you're having to fight off all the other issues while you're trying to fight to restore your health. So thanks for being willing to come today to provide very personal testimony. That's very helpful and we appreciated you doing that.

Now we have just a very small amount of time left, but we do want to hear as many as we can until 11:30, at which time we will have to adjourn, but we will ask that anyone who wishes to testify and has not been able to do so to submit a statement to either Senator Conrad's office or my office, and we will turn that statement over to the committee and it will become a part of the permanent hearing record that will be published. So I will apologize in advance that we won't get to all of you, but those who still wish to speak, we have about 8 minutes left and Stephanie Mohl has the microphone.

STATEMENT OF DENNIS RENVILLE, DIRECTOR, INJURY PREVENTION PROGRAM, UNITED TRIBES TECHINICAL COLLEGE

Mr. RENVILLE. Good morning, Senators Conrad and Dorgan. My name is Dennis Renville, and I work out here at United Tribes. I'm an enrolled member of the system of the Wahpeton-Sioux Tribe, and I will not take too much of your time. I'll allow time for the Elders from Fort Berthold.

I just want to say this: I think we have a very unique program out here at the United Tribes Technical College. It's one of a kind in the United States. It's a two-year degree program in injury prevention, and I was glad to hear Chairman Longie share the data with you, and Larry Dauphanais, I think provided some of that data for his presentation. Native Americans are experiencing epidemic rates of injuries, motor vehicle crashes, suicides. The point I want to make is we do have a 2-year degree program out here entirely funded by grants from IHS, National Highway Traffic Safety Administration and CDC.

United Tribes offers a unique opportunity because we get students every year from four different reservations across the country. This past year, our second year, we had students from four different—six different States actually. Four were from North Dakota tribes, three from South Dakota, one from Montana, Colorado, Minnesota, Nebraska, and Utah. The point I'd like to make is our program will empower students to go back to their respective reservations to make a difference in reducing the epidemic rate of injuries and fatalities.

IHS presently this past year went on record to indicate that they will provide scholarships for injury prevention students, which is a plus, and they also will be providing us another year of funding.

I just wanted to take that opportunity and allow the time for the

STATEMENT OF LUELLA YOUNG BEAR, MANDAN TRIBE

Ms. YOUNG BEAR. Thank you. Good morning, my dear people Thank you people up there that's running for office and want to get our Indian voices in there, and I sure thank you for that because we Indians, just like anyone else, like to have what we got coming We have a hospital that should come to us. When you make a payment for the big recreation area called Sakakawea, that's what I'm talking about, and so when you get into office, remember Fort Berthold Reservation, the Hidatsas, the Arikaras and the only Mandan, and that's me. You know, I'm a Mandan Indian that is one of the well-known Indians that was all wiped out with the smallpox.

We're talking health here. So I asked to come along and tell this to you people, and that—like I say, when we get a hospital that we have coming—you owe it to us, the Government owes us this hospital—when we get that, we've got all well-qualified physicians. Our Indian children are grown now and they're all good doctors, and that's why I say—that's what I want to testify for, is the one we're talking about, that Indian health.

There's so much trouble to it. I heard it all morning now. So maybe us Indians, if we get our hospital that we have coming, maybe we're going to be healthy as some of you White people are. Our death rate won't be so high, and this is what I have come to say.

I come from a little remote area called Mandaree, ND, and that's what I'm speaking for, is for my Mandans and the Hidatsas and the Arikaras. So, please, when you get into office and the excitement is over, remember what I'm saying here, and, too, we see where the recreation area is really doing good. Makes a lot of money for you White people, and that's why we say why are we so in debt when we have all this? Where is our share in that?

So this is a debt that is owed to us. We—I'm talking for a hospital that we should have had, and while I'm at it, put a helicopter with it so we can go fast.

Senator DORGAN. Ma'am, with that statement, you're going to want to have your name in this record. So could you tell us your name, please.

Ms. YOUNG BEAR. My name is Luella Young Bear. I'm a Mandan Indian.

Senator DORGAN. Luella Young Bear. Luella, thank you very much for being with us, and we appreciate your statement, very forceful and very forthright.

I'd like to call on Senator Conrad, if he has any concluding remarks. Then as I said, this is an official Senate hearing and what we're going to do is ask any of you to feel free to send us a statement to be a part of the published hearing record. Senator Ben Campbell and the committee, including Senator Conrad and I, will make it a part of the formal record, and we would ask that you submit to us any statement within the next 2 weeks. Let me, as we conclude, ask Senator Conrad for any comments he may have.

Senator CONRAD. Senator Dorgan, again, I want to thank you for

really isn't the thing we need to focus on. The pot is not big enough and is nowhere close to being big enough to meet the need that is out across Indian country, especially in the Aberdeen Area district.

I think the testimony that we received from Mr. Bad Moccasin indicating that we would need four to five times as much money as we're currently being allocated to deal with the real needs that are out there tells us the dimensions of this problem, and I think probably for the first time we have on the record of the congressional committee how very dramatic the gap is between what's provided and what's needed, and I'm just hopeful that because of this testimony, because of this record we will be able to close that gap as it clearly needs to be done.

Thank you. Thank all of the witnesses, thank everybody who has attended the hearing as well.

Senator DORGAN. Senator Conrad, thank you very much. Let me as I close tell you that when we are finished here, Senator Conrad and I are going to go to St. Alexius Hospital. My staff director here in North Dakota, Bob Valeu, had a heart attack yesterday, and he's hospitalized at St. Alexius. I'm happy to report that the prognosis looks quite good, but it was quite a shock yesterday. He was at my office here in Bismarck and suffered a heart attack and was taken to the hospital. You will, I'm sure, forgive us for wanting to go to the hospital to see Mr. Valeu. The prognosis from his doctor is that this is going to turn out all right and our hopes and prayers are with him.

Let me just make a final comment, as well. These are tough issues. Luella, who just testified spoke from the heart, as did all of you, that there are serious needs here, and it's not just a case of somebody asking, can you please help us. It's people saying, we deserve this. This is a responsibility. This is a trust responsibility that the Federal Government has to do the right thing, to meet its obligation. These are promises, and this country has not kept its promise. When Deborah talked about the young man, we could talk about 1,000 of those young men and women or senior citizens or others, and we would weep forever in this room if we began really to talk about what's been happening, what's been happening to people.

I remember reading in The Bismarck Tribune one day a story about the death of a young man on the Standing Rock Reservation, a young man who served with gallantry and bravery in Vietnam, signed up to serve again, and served this country with great bravery through two full terms of Vietnam and then died out here on the prairies. I had tears in my eyes as I finished reading that story thinking to myself why could we not have done something for this young man? He did something significant for his country.

And so we just need to do better. Senator Conrad and I are two voices in Congress who have the passion and the desire to make something happen. You know, there's a lot of talk—there's always a lot of talk. That's not what's important. What's important are the actions that are taken by the Congress of the United States to address real problems that people are facing every single day, and we

that we will do everything we can to try to address these issues on your behalf. This country needs to do better, and we're going to use our public service to see that it does.

Thank all of you very much, and again thank you for understanding our desire to leave to go see Mr. Valeu at St. Alexius.

[Whereupon, at 11:32 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MARLENE KREIN, PRESIDENT, MERCY HOSPITAL, DEVILS LAKE, ND

Thank you for the opportunity to provide testimony today regarding S. 2526. We are a faith based organization, and our values speak for human life and community service.

Mercy Hospital's service area is located in a rural agricultural community, with a primary service population of approximately 15,000. The southern boundary of our service area encompasses the Spirit Lake Nation, a community of approximately 2,500 Native Americans.

The plight of the American Midwest is a story that does not command front-page attention, the story theme has become an all too familiar saga. Small towns are becoming ghost towns and the inability of the rural community to attract and support industrial and technical business has resulted in a lack of good paying jobs.

Inland flooding that is unmatched for most of our history fails to attract attention if it is in a rural, sparsely populated area such as Devils Lake. We are in our 7th year of flooding with a land-locked lake that has risen over 25 feet and has flooded thousands of acres of productive farm land.

In spite of the many obstacles faced here, Devils Lake has an above-average opportunity to meet most primary and secondary health care needs. We have a single independent clinic of 15 physicians and 2 extenders. There is a clinic in Fort Totten that provides services during daytime hours Monday–Friday.

Mercy Hospital is the only, source of after hours care within our primary service area, and in spite of the inability to collect for much of the health care provided to the people of the Spirit Lake Nation, we continue to serve them.

Indian Health contract services are not adequately funded at our local service unit. We as a small, rural provider are disproportionately impacted by this lack of funding for provision of services that are clearly a Federal obligation. Medicaid volume at Mercy Hospital qualifies the hospital as one of two disproportionate share hospitals [non-government] in the State of North Dakota. We have an extremely busy emergency room, but are unable to cover the cost due to a high percentage of Medicaid volume and uncompensated Indian Health visits. Indian Health Service refuses to recognize after hours emergency care for payment, except life-threatening conditions. Services to Native Americans in our emergency room account for at least 40 percent of our total outpatient emergency room volume. North Dakota Medicaid pays for 65 percent of this volume. The remaining volume is potentially funded or rejected by Indian Health Service as self-pay or indigent care. In addition, funding for other acute services provided is always inadequate.

In the case of obstetric care, of which our payor mix is 50 percent Medicaid, Mercy Hospital is forced to subsidize service to this population in excess of $150,000 a year. Often there is no payment for this care when Indian Health says the mother failed to apply for Medicaid. Payment is also denied for children under age 18 when Indian Health Service believes they are eligible for CHIPS.

Our request that Indian Health Service pay their fair share for resources consumed has become increasingly important as payors set rates at dangerously low levels. Blue Cross of North Dakota, a dominant commercial payor within the State, has implemented draconian reductions in fee schedules within the last 2 years. In addition, Medicare has passed outpatient PPS, and Medicaid will soon follow. With the rules and regulations of today, there is no means to "fix" the current problem.

The unwillingness of Indian Health Service to reimburse Mercy Hospital for services rendered affects not only the operations of the hospital, but also the entire staff and community. The non-payment of these accounts can no longer be born by the community at large. Last year, staff at Mercy Hospital did not receive salary increases, due in part because of Indian Health Service payment uncertainty. The staff time required to process the Indian Health Service claims is quite disproportionate to the number served. The fluctuations in accounts receivable has led to numerous meetings with the local Indian Health Service, Congressional Delegation, the Tribal Board and Tribal Chair. There is a spirit of collaboration between these agencies, but government guidelines for this program have made it impossible to find a lasting solution to the most basic business principle reimbursement for services rendered.

I support reauthorization of this bill, but ask for appropriate funding or avenues we can take together to serve the Spirit Lake Nation and insure that Mercy Hospital is reimbursed. Mercy Hospital would like to be part of the solution.

I remember a few years ago when Senator Conrad asked me at what point Mercy Hospital would be unable to serve with the lack of reimbursement. My answer at that time was, "I would find a way." Today, my answer is, "we are dangerously close to having to reduce or eliminate services." My responsibility is to serve the entire community and do whatever I can to insure that Mercy Hospital remains viable. It is imperative that Indian Health Service reimburse adequately for services rendered if we are: to fulfill our commitment to the individuals and communities we serve.

PREPARED STATEMENT OF BIRON D. BAKER, M.D., THREE AFFILIATED TRIBES PHYSICIAN

Prescription Drugs are the current "hot item" in healthcare today. When folks debate the cost of healthcare, drugs inevitably enter the conversation because of their costs, and nearly anyone can quote how much they paid for a particular drug. This is true for Indian Health Service patients, with a bit of a different twist to it.

It seems physicians are always in the position of explaining to the patients why we don't have some of the "latest" drugs. Our explanations begin and end in terms of funds. At Fort Berthold, the Service Unit has currently expended more than $300,000 purchasing drugs. We were budgeted for about half of that amount. By the end of the fiscal year, we will have expended over 1 million. Our recurring budget at Fort Berthold has not exceeded 500,000, but costs continue to rise. We purchase primarily from Amerisource, our prime vendor. We can obtain medications at considerably less cost through them, yet costs outpace the budget. The number of prescriptions filled at Fort Berthold continues to rise. In 1996 there were 39,890. The projected number for 2000 is 80,000. Access to medications will soon be a bigger issue when we are forced to limit services.

Patients' perceptions are that a lot of drugs aren't available. We do have the "latest" drugs for diabetes, arthritis, cardiovascular diseases, and other conditions. Most of these medications are not generic as patients tend to believe. The cost of these medications is phenomenal, but we have them because they're necessary. Some of our new medications are "non-formulary", meaning only a few patients have access. Typically, these are our sickest patients. A Cardiologist recommends a particular medication for a patient, it is purchased and dispensed. If we ignore the recommendations of our consultants, it would seem unwise to seek consultation to begin with. If patients had to purchase these medications for themselves, their costs would be even greater. The following listing of medications are typical monthly supplies, and cost to the patient:

Metformin 500 mg [60 tablets] $41.95.
Avandia 8 mg [30 tablets] $125.19.
Prevacid 30 mg [30 capsules] $106.77.
Lipitor 20 mg [30 tablets] $84.27.
Celebrex 200 mg [60 capsules] $32.68.
Norvasc 5 mg [30 tablets] $41.95.

tients, this will serve only to alienate Indian Health Service from its patient popu lation. We would never want to be in a position of choosing patients for treatment If in the future only three out of five diabetic patients can be treated with the lates drugs, I certainly don't wish to be in a position to select three and ignore two o my patients.

As a group, I think Indian Health Service physicians are the most responsibl physicians in the Nation when choosing medications for their patients. We nearl always follow formulary guidelines, and we tend to use older medications whenevei we can. At the risk of sounding simplistic, we need more money. Thank you for you time and attention today.

PREPARED STATEMENT OF CDR ERNEST R. SCOTT, CHIEF PHARMACIST, FORT YATES PUBLIC HEALTH SERVICE HOSPITAL, FORT YATES, ND

Good morning, Chairman Dorgan, My name is Ernest Scott, and I am the Fort Yates Public Health Service Hospital Chief Pharmacist. In brief, I began my career as a practicing pharmacist in 1969 with a 1-year internship with the Oklahoma City VA Hospital. After this internship, I entered into private retail pharmaceutical practice, working first as director and owner/operator of a 265-bed hospital pharmacy for 11 years, and then served as a consultant to a psychiatric care facility for 9 years, It was after this private practice experience, that I joined the Indian Health Service [IHS] to work with the Fort Yates, ND in 1988.

The IHS Aberdeen Area operates 8 hospitals, 8 health centers and 12 health stations. Additionally, tribes now operate 6 health centers, 1 school health center and 3 health stations. In Fiscal Year 1997, the IHS total user population was more than 1.3 million, while the Aberdeen Area's user population count was approximately 113,064 of this total. According to the 1990 Census, the medium household income in 1989, for Indians residing in States with reservation communities, was $19,897. The Aberdeen Area's Indian household median income was found to be $12,310 for this same period.

Provision of health care services, to the nine tribal communities within this region, encompasses preventive, acute and chronic care services. This also includes appropriately prescribed pharmaceuticals in these various and diverse care settings. Today, I would like to provide a brief overview of how these prescription drugs, or over-the-counter [OCT] drugs, are selected and made available to our Indian patients.

A formulary is a continually revised list of pharmaceuticals and important ancillary information. The Area Pharmacy and Therapeutics [P&T] committee is responsible for the development of Area formulary, a list of core pharmaceuticals for Area facilities. The selection of the drugs contained within the formulary is based on efficacy, drug costs, and prescribing practices within the Area. The Area P&T committee is composed of the Chief Medical Officer, the Area Pharmacy Officer, [1] Clinical Director from each service unit, a nursing representative, and at least 1 pharmacist. The Area formulary represents the current clinical judgment of the clinical staff, and is reviewed and updated each year.

PREPARED STATEMENT OF THOMAS CROWS HEART, VETERANS SERVICE OFFICER, THREE AFFILIATED TRIBES, NEW TOWN, ND

Talking points for Veterans Health Care: Our history of service in the United States military goes back to the 1860's when members of the Arikara served as scouts for the United States Army. Tribal members, both men and women served in the Spanish American War, WWI, WWII, Korea, Vietnam, and Desert Storm.

Many of those who served were not United States citizens when they served this country. Today, we have approximately 900 veterans residing on the Fort Berthold Reservation with many more residing off the reservation. Those, individuals have indicated they would come back if they could be assured of medical services.

There are 300 on file in Tribes Veterans Service Office. The majority of service to these individuals is medical assistance, with transport to medical facilities being the leading reason that veterans contact the Veterans Service Office.

Currently, there are 15 veterans residing on the reservation who are wheel chair bound. Dialysis, diabetes, heart conditions, strokes, cancer, and services for dental care and eyewear top the list of medical problems veterans seek out help from the Veterans Service office.

Distance to VA Medical Centers and facilities:
Miles City VA Medical Center—218 miles [436 miles roundtrip]
Fort Meade, SD VA Medical Center—310 miles [620 miles roundtrip]
Fargo VA Medical Center—350 miles [700 miles roundtrip]
Minot VA Clinic, Minot AFB—93 miles [186 miles roundtrip]
Bismarck VA Clinic, Medical Center One—160 miles [320 miles roundtrip]
Federal facilities have a 6-month waiting list for hospital services.

Veterans who served this country are caught between 2 agencies, Indian Health Service and the Veterans Administration.

Indian Health Service refers them to the VA and the VA sends them back to IHS because they are cutting back services.

There is a Post War Trust Fund funded by the State which provides help for extreme emergencies only and there is a limit on the funds available per year for each veteran.

There is a definite need for a Preventative Health Care Facility or a hospital to serve the needs of our people, particularly those who served this Nation.

PREPARED STATEMENT OF MARILYN C. HUDSON, MEMBER, THREE AFFILIATED TRIBES, FORT BERTHOLD RESERVATION

Senators Dorgan and Conrad, members of the committee:

My name is Marilyn Hudson. I am a member of the Three Affiliated Tribes of the Fort Berthold Reservation. I am here to present comments on S. 2526, to amend the Indian Health Care Improvement Act to revise and extend such act.

I will speak on the urgent need for the development and implementation of a comprehensive home heath care program. Our elder population, those aged 60 and older, number 600, 6 percent of our total tribal membership of 10,000. These 600 elders are a very special group of people. They represent the remaining adult group displaced from their ancestral homes in 1954 as a result of the flood waters of the Garrison Dam. I was 18 years of age at that time and I am a part of this group.

We came from an agricultural background, families who lived on their own allotments and who raised gardens and livestock. Elders remained in their home and were cared for by the extended family group. When I was a child, almost every family in my neighborhood had an elder residing in their household. This traditional practice is now impossible to maintain because of the geographical fragmenting of the reservation and the destruction of the farming and ranching economy. Most households now find both parents working in order to make ends meet. Many young families had to leave the reservation to secure employment. As a result, many elders now face growing old alone and without the support group their parents and grandparents enjoyed.

Like the rest of America, we too have a growing elder population. In 1936, the year our tribe adopted the Indian Reorganization Act and elected their first Tribal Business Council, there were only 105 people age 60 or older. Today, that number has increased nearly 6-fold. Growing older brings with it susceptibility to more health problems like diabetes and hypertension. Like all other Americans, Indian seniors want to stay in their own homes as long as possible. Therefore, we need services which will enable us to remain independent in our homes.

Recently, I served as the Social Security representative payee for a tribal member who was undergoing intensive treatment for cancer. While recuperating, he spent some time in the nursing home and some time in a small apartment. I was able to see first-hand how he would have benefited from a well-planned home health care program. There are many other examples such as, the one I mentioned.

Designing programs which will keep elders independent in their homes for as long as possible will in the long run save money. The cost of nursing home care is extremely high and ever on the increase.

I wish to thank all of you for your efforts to bring better health care services; to our reservations. I appreciate the opportunity to be here today and provide you with my comments.

PREPARED STATEMENT OF EDWARD MANUEL, CHAIRMAN, TOHONO O'ODHAM NATION, ARIZONA

Thank you for this opportunity to provide testimony on the Indian Health Care

of the Indian Health Care Improvement Act and my comments today reflect both my views and those of the members of the National Steering Committee.

The Senate Bill, S. 2526 is nearly a duplicate version of the consensus bill developed by tribes last May–October in what was a good example of a serious consultation process. This bill was developed by tribes and urban Indian groups and reviewed and commented on by American Indians and Alaska Natives nationwide Tribes appreciate the committee's willingness to put forward our consensus bill for comment, debate, and ultimately passage.

The purpose of title VIII is to provide authority for various purposes that do not fit neatly into the categories that make up titles 1–7. The National Steering Committee was very businesslike in cleaning up the old title VIII, which by its very nature as a residual title tends to collect many authorities, particularly related to reports. Ten sections were moved out of title VIII to more appropriate sections in the IHCIA. All CHS provisions were moved to title II. A majority of the "free-standing and severability" provisions were incorporated into title VIII or title III. Section 801 contains a listing of all reporting requirements contained in the bill.

New language is proposed regarding negotiated rulemaking procedures in section 802 requiring the Secretary to initiate these procedures 90 days from the date of enactment. This section establishes a maximum amount of time for negotiated rules to be printed in the Federal register, not later than 270 days after the date of enactment. The authority to promulgate regulations under this act expires after 18 months from the date of enactment, forcing an expedited rulemaking process. Section 803 requires the Secretary, in consultation with tribes and urban Indian organizations, to develop a "plan of implementation" for all provisions of this act. Section 804 continues the prohibition on abortion funding, as it exists in current law.

Section 812 contains the Eligibility Moratorium and provides that the Secretary shall continue to provide services in accordance with eligibility criteria in effect on September 15, 1987 until such time as new criteria governing eligibility for services are developed in accordance with the negotiated rulemaking provisions in section 802. Negotiated Rulemaking is required before implementing revised eligibility standards. This will enable Indian tribes to have a meaningful involvement to resolve the differences of eligibility for HIS services, Such involvement would be consistent with Federal policy of tribal consultation and the government-to-government relationship.

A major amendment is proposed in section 816, with the establishment of a National Bipartisan Commission on Indian Health Care Entitlement. The National Steering Committee, based upon strong recommendations from the Regional and National consultation meetings, examined the establishment of an entitlement provision for Indian health services through the IHCIA reauthorization process. The committee found that the number of issues related to the establishment of an entitlement provision, and the need for extensive and representative tribal consultation required further study. A Commission was therefore proposed. The Commission will review all relevant data, make recommendations to Congress, establish a "Study Committee", and submit a final report to Congress. The membership of the Commission will be 25 members, including 10 Members of Congress, 12 persons appointed by Congress from tribal nominees who are members of tribes, and 3 persons appointed by the director of the IHS who are knowledgeable about health care services for Indians, including 1 who will specifically address urban Indian issues, Meetings require that a quorum of not less than 15 members be present, and that not less than 9 of those members be Indian, to conduct business. The Commission will have the power to hire staff, hold hearings, request studies from the General Accounting Office, the Congressional Budget Office and the Chief Actuary of HCFA, detail Federal employees, and expend appropriated funds. Two reports are proposed. The first report on findings and recommendations must be made to Congress not later than 12 months from the date all members are appointed. The second report on legislative and policy changes must be made not later than 18 months from the date all members are appointed.

The two significant provisions of this title are the negotiated rulemaking section and the Entitlement Commission.

Section 802, authorizing negotiated rulemaking, was debated at several of the National Steering Committee meetings, in comments to the July 16 draft, and in the workgroups. The consensus was to include both section 802 and the various specified instances were rulemaking would be mandatory.

Last year at the National Forum on Reauthorization I, along with over 40 other tribal leaders, agreed to work on the concept of making Indian health an entitle-

The composition and charge of the commission were debated at the August 31, 1999 Salt Lake City meeting of the entitlement workgroup, chaired by Julia Davis. In fact the debate continued at the October 5, 1999 meeting in Palm Springs before agreement was reached on the current composition and charge of the Entitlement Commission.

The Entitlement Commission, if established, would likely consider eligibility and perhaps eliminate the need for section 811's call for negotiated rulemaking on this subject. Many feel that a commission that includes tribal and congressional leaders would be more appropriate to perform this critical task.

Thank you again for the opportunity to share the views of the National Steering Committee with this committee.

PREPARED STATEMENT OF DENNIS RENVILLE, DIRECTOR, INJURY PREVENTION PROGRAM, UNITED TRIBES TECHNICAL COLLEGE

I just want to followup on my short statement for the record this morning. As I indicated, United Tribes Technical College has the only undergraduate injury prevention degree program in the country. The concept of the injury prevention practioner is new and truly exciting. The objectives of this program are to place qualified injury prevention specialists in positions with local, national, and tribal organizations to reduce injuries among Native Americans. You heard the epidemic injury and death rates that Native Americans are experiencing this morning from Chairman Longie from the Spirit Lake Tribe. This is unacceptable, and if these rates were impacting any race other than American Indians, I am positive that Congress would appropriate special funding immediately to address this issue. Enough said on that statement.

Therefore, the goal of the injury prevention program shall be to decrease injury morbidity and mortality among Native American people. The United Tribes Technical College Injury Prevention Program assist students to become proficient in the development, implementation, and evaluation of grassroots interventions. This will be accomplished by coordinating and collaborating with State and national traffic safety and injury prevention agencies and public entities.

I am requesting your support for additional funding for injury prevention in the Reauthorization of the Indian Health Care Improvement Act. I feel this is truly a unique and innovative program that will reduce injuries, deaths and contract health service funding impacting Native Americans.

Additional funding could be used to create job opportunities for the students graduating from the United Tribes Technical Injury Prevention Program. This past year [fiscal year 2000] the Indian Health Service awarded approximately $1.5 million for grants to the tribes, nationally for injury prevention programs. This amounted to 15 new jobs in injury prevention in Indian Country and it is my understanding that they are planning another 20 grants next year if the funding is available. Also the Indian Health Service will be including injury prevention students in there 437 scholarship program this year. This is a major milestone for injury prevention but more is needed. I too, would like to recommend a section 716 be added to the act addressing injury prevention programming.

In closing, I might add that our injury prevention program was developed with technical assistance from the University of North Carolina Injury Prevention Research Center, Centers for Disease Control, and the National Highway Traffic Safety Administration. I feel we have an excellent program that was long over due for Native Americans and I hope we can count on you for continued support for this new and innovative program.

Thank you.

Remember! Injury prevention is the best medicine.

SPIRIT LAKE TRIBE

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UNITED STATES SENATE
COMMITTEE ON INDIAN AFFAIRS
HEARING ON DRAFT LEGISLATION
REAUTHORIZING INDIAN HEALTH CARE
IMPROVEMENT ACT
AUGUST 4, 2000

ORAL STATEMENT

PHILLIP "SKIP" LONGIE
CHAIRMAN, SPIRIT LAKE NATION

Chairman Campbell, Senator Dorgan, Senator Conrad, Members of the Committee:

Thank you for the opportunity to present testimony today. My name is Phillip Longie. As Chairman of the Spirit Lake Tribe I welcome you to the Aberdeen Area and the State of North Dakota.

Initially, I want to state my support for the draft health care legislation to re-authorize the Indian Health Care Improvement Act, Senate Bill 2526. I will briefly point out some of the health care issues related to Section VII - Behavioral Health Prevention and Treatment Services, more specifically Injury Prevention and its relationship to health care cost and its impact to morbidity and mortality of our American Indian people.

As a Tribal Leader; member of the Aberdeen Area Tribal Chairman's Health Board and Area Representative to the National Level of Need Work-Group, it is evident daily the impacts of inequities and disparities in health care provision affecting our American Indian people.
Poor health status, huge work loads, inadequate access & restricted access for the prevention funding affects the health care and health care costs to Aberdeen Area and Indian Country. Statistically, a high number of injuries and hospitalizations in the Aberdeen Area require more contract dollars than we have. Reduction of injuries would result in having more dollars available for other CHS needs.

Regardless of the Indian Reservation, many tribes share similar concerns and experience the direct correlation between poverty, injury deaths and longevity of life. This testimony will concentrate on the impacts of injuries to to children ages 0-19. The majority of the injuries are influenced by alcohol, substance abuse, behavioral health and violence.

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

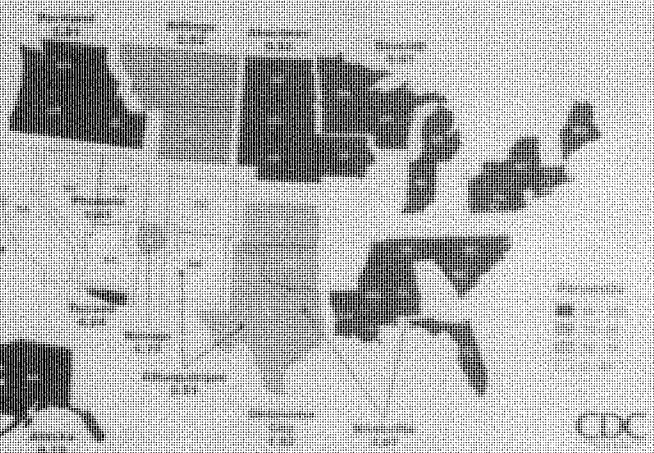
LIFE EXPECTANCY DISPARITIES
Tucson
Portland
Phoenix
Oklahoma
Navajo
Nashville
California
Billings
Bemidji
Albuquerque
Alaska
Aberdeen
0.0 10.0 20.0 30.0 40.0 50.0 60.0 70.0 80.0
Indians
U.S. All Races

Spirit Lake Tribe-Chairman Phillip "Skip" Longie
Leading Causes of Death
Native Americans, Aged 1-19 Years, 1992-1996
Unintentional Injuries
Homicide
Suicide
Cancer
Heart Disease
Other
Injuries accounted for 75% of deaths among Native Americans aged 1-19 years in the Aberdeen area from 1992 to 1996.
This compares to 61% which is the U.S. National average.

pirit Lake Tribe-Chairman Phillip "Skip" Lengle
Ten Leading Causes of Death, by Age Groups,
American Indians and Alaskan Natives (IHS), 1979
Injury is the leading cause
of deaths for ages 1 to 44

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

Native American Fire and Burn-Related Deaths per 100,000
Ages 0-19, 1985-1996, IHS Areas



- In 1993, Spirit Lake Tribe had five fires within a 3 month period that took the lives of eleven tribal members ranging in age from ten to sixty-two.
- Aberdeen Area ranks first in the nation's IHS Areas with loss of life to Fire and Burn related deaths for ages 0-19 for 1985 - 1996 (3.62%)

Spirit Lake Tribe-Chairman Phillip "Skip" Longie
Native American Suicides per 100,000
Ages 0-19, 1985-1995, IHS Area

›irit Lake Tribe-Chairman Phillip "Skip" Longie

bal Chairman Phillip Longie
gust 1, 2000 Testimony
marck, ND

: recommend that a Section 716 be added to the Act addressing Injury Prevention Programming.

Develop prevention and intervention models for injury prevention services and needs

That such funding be appropriated as may be necessary to fund injury prevention services at the Service Unit level as a line item program

Add injury prevention as a priority for the Indian Health Profession Scholarships

Provide scholarships for higher education and/in - school training at the local tribal college level fo injury prevention specialists and technicians

As on other Aberdeen Area Reservations the staffing for mental health does not meet the need. W 5,500 people residing on my reservation and over half being under the age of 18; We have ONE mental health worker.

: recommend a separate Childhood Injury Act or initiative to prevent injury and save the lives of our ildren.

ere were over 800 treaties between the U.S. and Indian Tribes with fewer than 350 ratified by Congres ıce March 2, 1871 Congress repealed the acceptance of further treaties.
e number of tribes recognized has increased to over 520. Annually, more
bes seek federal recognition, yet federal appropriations remain based on the original treaties. Not :ounting for the increase of 170 tribes and their population.

nators and Committee Members it is imperative that as you contemplate a decision on Senate Bill 2526 u keep in mind our children yet to come. Acknowledge the true reality of the health care needs, the ıtems weaknesses, the neglected voids, and the unequal quality of health care access in Indian Country.

leaders of two nations we must respect the history we have both passed through and the history we are ıking today.

ank you.

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

FORT TOTTEN INDIAN HEALTH SERVICE
MENTAL HEALTH AND SOCIAL SERVICES
P. O. BOX 309, FORT TOTTEN, ND 58335 *701-766-1613*

31 July 2000

Mr. Philip "Skip" Longie
Spirit Lake Tribal Chairperson
Fort Totten, ND 58335

RE: Information on Prevention Needs from a Mental Health Perspective

Dear Mr. Longie,

First of all, thank you for the opportunity to outline some of the identified community needs in the mental health area. As I know you are aware, this is a tragically underfunded area of health care for the People of the Spirit Lake Nation and Indian Country in general. Any access to additional resources will be not only appreciated, but also will be reflective readily in the lives that will be both saved from suicide and that will improved within the holistic traditions of the community.

Nationally, suicide rates having consistently hovered around the 11 – 13 per 100,000 range for many years. I completed an analysis of the suicide rates on the Spirit Lake Nation through 1998 (the most recent year for which I have compiled data). Although in the United States as a whole, suicide rates are highest for elderly white males, Spirit Lake has a different profile. The numbers here reflect suicide rates as highest for youth aged 15 – 24, mostly females. As I present the following numbers, I would ask that you keep in mind the national figure of approximately 12 suicide deaths per 100,000. In 1996, the suicide rate for youth aged 15 – 19 was 1152.74 per 100,000 – approximately 97 times the national average! The rate for 15 – 24 year olds was 648.30 per 100,000, indicating the majority of deaths were in the 19 and under category. For 1997, the number for 15 – 24 year olds decreased to 324.15 per 100,000 following the activation of a crisis response team. With continued utilization of the crisis response team, the suicide rate for the 15 – 24 year old age group continued to decline to 162.07 per 100,000. Although this is a very significant decrease, it still reflects an unacceptable statistic from my perspective. An equivalent statistic that illuminates the depth of the problem is that in 1998, 10 youth from the Spirit Lake Nation would die for every 1 death by suicide in North Dakota as a whole.

Of course, the actual number of death in 1998 was not 10 – it was 1. However, that individual was a human being who made the decision that death was a preferred option over life. The statistic tells us that the impact of that single death in our community carries the equivalent impact of over 162 youth in Fargo dying by suicide. Had that occurred, rest assured there would have been a significant public outcry and immediate action to implement change taken. Unfortunately, our funding sources in the community have remained constant – and severely underfunded at that – despite these figures. The impact of a dedicated group to making positive change in the lives of young people has contributed greatly to the noted decrease in rates by developing a team that serves as a safety net to catch **most, but not all** children at risk. However, we are at a point where we need to develop community based and culturally sensitive resources to improve that effort in building strengths and provide healthy alternatives for youths to achieve their potential.

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

Approximately 50% of the population of the Spirit Lake Nation is 21 or younger. With suicide rates that are over 10 times the national average (Indian Country as a whole has a suicide rate that is 3 times the national average with clear tribe specific differences), we need to begin preventative efforts now or the youth will be lost. Suicide is the third leading cause of death for young people. Furthermore, for each death by suicide, on average six family members and friends are directly impacted. Given the higher rates of youth in our communities, this number is certainly higher as well. The spiritual, emotional, and mental costs to the communities are astronomical. Again imagine the impact of almost one thousand people in Fargo directly experiencing the loss of a loved one by suicide. This is not to mention the contagion in attempts that often occurs following a suicide and the emotional impact in schools, recreation centers, and other places where youth will face the loss of a friend. Also, Indian communities tend to be more interconnected given the kinship systems and because they are pockets of population within a dominant culture that is largely unsympathetic to historical grief and the long term ramifications of forced acculturation through warfare. An appropriate analogy can be made with the plight of survivors from the Nazi Holocaust.

Given that the Spirit Lake statistics (and by no means do I mean to reduce the human face of this tragedy to mere numbers) indicate a loss of youth and particularly females, prevention efforts should focus on these areas. The development of positive self esteem through cultural awareness, problem solving skills, and adaptive coping skills will bring further health and healing to the communities. Specific efforts should be made to improve the lives of girls through empowerment. The causes for such problems are intertwined and will not be resolved overnight. However, we know that suicide rates and depression are adversely impacted by child neglect, substance abuse, and sexual abuse. There are vast opportunities for continued improvements in these areas as well. The grassroots effort has begun. People are recognizing a need for change. However, the tangible resources of supplies and finances are limiting what efforts can be accomplished and this is how your current support can be of extreme value.

Preventing the further loss of youth through suicide has been my primary effort since coming to Fort Totten in 1997. However, there are many other significant concerns, several of which were alluded to in the previous paragraph. Others that are responsive to prevention are domestic violence and chronic pain management. Narcotic use shows increased use over the past several years, yet no funding exists for prevention. Biofeedback, stress management, and inpatient treatment for chronic pain are highly effective interventions as well as prevention for the development of narcotic addiction. Unfortunately we cannot meet these needs with current limited resources both from a financial and personnel stance. Ability to provide such services would decrease the money spent on narcotic medication and ER visits as well as increase the time available to providers to see patients with other concerns and the overall functioning of persons with chronic pain.

I sincerely hope this information is helpful to you and subsequently of benefit to the People of the Spirit Lake Nation. If you have questions, please do not hesitate to contact me at 766-1613. Thank you.

Respectfully,

PsyD FICPP

Greg Volk, PsyD, FICPP
Director of Mental Health and Social Services

cc: File
Marj Archambault, SUD

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

DRAFT: Health DISPARITY Index 06/13/2000

HEALTH DISPARITY RELATED TO POVERTY

	USERS	% Indians Below Poverty	% US Poverty	EXCESS Indian %	EXCESS # IN POOR HEALTH	DISPARITY INDEX
ABERDEEN	118,800	49.6%	13.1%	36.5%	9,626	163%
ALASKA	113,885	24.0%	13.1%	10.9%	2,756	49%
ALBUQUERQUE	85,391	42.1%	13.1%	29.0%	5,497	130%
BEMIDJI	86,291	33.0%	13.1%	19.9%	3,812	89%
BILLINGS	69,068	44.6%	13.1%	31.5%	4,830	141%
CALIFORNIA	63,615	24.0%	13.1%	10.9%	1,539	49%
NASHVILLE	38,565	24.7%	13.1%	11.6%	993	52%
NAVAJO	253,363	44.6%	13.1%	31.5%	17,718	141%
OKLAHOMA	300,267	27.0%	13.1%	13.9%	9,266	62%
PHOENIX	135,581	41.8%	13.1%	28.7%	8,638	128%
PORTLAND	87,488	29.2%	13.1%	16.1%	3,127	72%
TUCSON	23,172	24.0%	13.1%	10.9%	561	49%
IHS	1,375,486				68,364	

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

LIFE EXPECTANCY DISPARITIES

	USERS	INDIANS	US ALL RACES	DISPARITY	TOTAL DISPARITY YEARS	Life Expectancy Disparity Index
ABERDEEN	118,800	64.8	75.8	11.0	13,068	222%
ALASKA	113,885	69.1	75.8	6.7	7,630	135%
ALBUQUERQUE	85,391	72.6	75.8	3.2	2,733	65%
BEMIDJI	86,291	65.1	75.8	10.7	9,233	216%
BILLINGS	69,068	67.2	75.8	8.6	5,940	174%
CALIFORNIA	63,615	76.4	75.8	-	-	0%
NASHVILLE	38,565	72.7	75.8	3.1	1,196	63%
NAVAJO	253,363	72.5	75.8	3.3	8,361	67%
OKLAHOMA	300,267	74.3	75.8	1.5	4,504	30%
PHOENIX	135,581	69.0	75.8	6.8	9,220	137%
PORTLAND	87,488	71.0	75.8	4.8	4,199	97%
TUCSON	23,172	66.9	75.8	8.9	2,062	180%
IHS	1,375,486				68,146	

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

CATASTROPHIC TRAUMA RELATED INJURY EVENTS

Three Affiliated Tribes	
Year/Event	**Cost**
1995	
Stabbing/Gun Shot	34,017.12
1996	
Non Submitted	0.00
1997@	
Motor Vehicle	52,724.50
Motor Vehicle	39,666.14
Total	**$126,407.76**
Total Motor Vehicle	**$92,390.64**

Spirit Lake	
Year/Event	**Cost**
1995	
Frost Bite	27,742.93
Head Injury-Trauma*	26,711.14
Motor Vehicle	228,899.00
Motor Vehicle	25,700.00
Motor Vehicle	196,165.72
1996	
Non Submitted	0.00
1997@	
Non Submitted	0.00
Total	**$505,218.79**
Total Motor Vehicle	**$450,764.72**
Grand Total Motor Vehicle	***$669,681.61***

Turtle Mountain	
Year/Event	**Cost**
1995	
Chemical Burns	17,899.34
Motor Vehicle	21,285.09
1996	
Fracture Mandible*	31,997.44
Solvent Injestion	37,102.69
Motor Vehicle	27,054.74
Motor Vehicle	21,025.75
1997@	
Stab Wounds	27,620.40
Assault	34,934.00
Motor Vehicle**	25,647.04
Motor Vehicle**	31,513.63
Total	**$276,080.12**
Total Motor Vehicle	**$126,526.25**

Standing Rock	
Year/Event	**Cost**
1995	
Non Submitted	0.00
1996	
Non Submitted	0.00
1997@	
Frost Bite	23,432.96
Total	**$23,432.96**

*Cause of injury could not be determined by information in Area Office files.

**Two charges for same case.

@Data submitted year-to-date.

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

FY 1999 TRAUMA CASES

Information taken from FY 1999 CHEF cases submitted to Area for reimbursement through Headquarters CHEF funds.

Type of Trauma	Cause	SU	Cost
Head injury	Snowmobile Accident	Belcourt	$27,669
Fx. Pelvis	MVA	Ft. Thompson	$32,784
Skull Fx.	MVA	Ft. Thompson	$121,932
Head Trauma	MVA	Ft. Thompson	$27,428
Multiple Fx.	MVA	Ft. Thompson	$30,344
Multiple Fx.	MVA	Ft. Thompson	$17,312
Multiple Fx.	MVA	Ft. Thompson	$32,784
Multiple Trauma	MVA	Ft. Totten	$58,989
Multiple Fx.	MVA	Ft. Totten	$70,047
Multiple Trauma	MVA/Cat Event (4 pts)	Ft. Totten	$92,795
Jaw Fracture	Assault	Ft. Yates	$34,241
Fx. Pelvis	MVA	Pine Ridge	$26,918
Head Trauma	Gunshot Wound	Pine Ridge	$25,551
Multiple Fx.	Fall/Toronado Victim	Pine Ridge	$9,750
Skull Fx.	Toronado Victim	Pine Ridge	$11,300
Scalp Injury	Toronado Victim	Pine Ridge	$32,689
Fx. Tib/Fib	Fall/Toronado Victim	Pine Ridge	$1,964
Fx. C5&C6/T8&T9	Toronado Victim	Pine Ridge	$80,996
Facial Lacerations	Toronado Victim	Pine Ridge	$33,136
Head Trauma	MVA	Rosebud	$21,589
Burns	Car Fire	Sisseton	$350,000
Spinal Cord Injury	MVA	Sisseton	$141,746
Cervical Spine Fx.	MVA	Santee	$52,127

TOTAL **$1,334,090**

CONTRACT HEALTH CARE
TOTAL DOLLARS EXPENDED FOR INJURIES
FY95

Injury Type / Service Unit	Motor Vehicle	Water Transport	Air Transport	Accid. Poisoning	Accidental Falls	Fires/Flames	Env. Factors	Stings/Venoms	Animal Related	Drown/Submer.	Cut/Piercing Obj.	Firearms	Machinery	Suicide Attempts	Assaults	Battered Child	Undetermined	Other Causes	TOTAL
Crow Creek	6,205	0	0	1,207	5,227	0	1,531	0	0	0	0	0	0	5,484	3,435	0	132,921	3,513	159,522
Cheyenne River	10,484	0	0	0	7,992	0	0	0	0	0	0	0	0	1,968	10,115	0	105,980	0	136,539
Flandreau	NO REPORT																		
Ft. Berthold	2,819	0	0	0	2,154	1,400	0	0	0	0	0	0	0	5,924	31,670	0	229,457	0	273,424
Ft. Totten	30,537	0	0	1,832	9,931	0	0	0	0	0	0	0	0	2,754	9,445	0	373,348	14,271	442,119
Lower Brule	4,316	0	0	0	4,311	0	0	0	0	0	0	0	0	2,248	2,135	0	95,780	1,287	110,077
Omaha	NO REPORT																		
Pine Ridge	50,342	0	0	0	31,011	16,855	0	0	0	0	7,113	0	0	1,768	54,984	0	710,863	19,567	892,503
Ponca	NO REPORT																		
Rapid City	21,450	0	0	2,798	696	0	0	0	0	0	3,056	0	0	3,803	2,778	0	239,445	0	274,025
Rosebud	45,282	0	0	6,745	28,674	696	7,313	0	0	0	0	0	0	9,430	72,660	0	327,221	7,514	503,534
Sac & Fox	NO REPORT																		
Sisseton	23,312	0	0	0	8,085	0	0	0	0	0	5,072	0	0	7,078	0	0	142,110	0	185,657
Standing Rock	18,203	0	0	0	36,471	0	0	0	0	0	0	0	0	3,367	4,745	0	321,756	0	384,542
Trenton	NO REPORT																		
Turtle Mountain	60,248	0	0	0	17,274	0	0	0	0	0	0	0	0	9,854	31,546	0	248,657	8,534	376,112
Winnebago	3,944	0	0	0	10,096	0	0	0	0	0	0	0	0	0	0	0	77,699	0	91,739
Yankton/Santee	26,474	0	0	1,912	0	0	0	0	0	0	0	0	0	34,025	4,293	0	234,770	11,747	313,221
TOTAL	303,613	0	0	14,494	159,922	18,951	8,843	0	0	0	15,241	0	0	87,703	227,806	0	3,240,008	66,433	4,143,013

CONTRACT HEALTH CARE

TOTAL DOLLARS EXPENDED FOR INJURIES

FY96

Injury Type / Service Unit	Motor Vehicle	Water Transport	Air Transport	Accid. Poisoning	Accidental Falls	Fires/Flames	Env. Factors	Stings/Venoms	Animal Related	Drown/Submer.	Cut/Piercing Obj.	Firearms	Machinery	Suicide Attempts	Assaults	Battered Child	Undetermined	Other Causes	TOTAL
Crow Creek	2,586	0	0	0	0	0	0	0	0	0	0	0	0	5,306	0	0	105,131	98	113,121
Cheyenne River	19,717	0	0	0	19,828	0	0	0	0	0	0	0	0	2,203	0	19,965	123,768	0	185,481
Flandreau	NO REPORT																		
Ft. Berthold	3,475	0	0	0	18,804	0	0	0	0	0	2,848	0	0	0	8,508	0	144,429	11,854	189,918
Ft. Totten	5,372	0	0	0	4,997	593	0	0	0	0	0	0	0	6,660	0	0	216,758	0	236,600
Lower Brule	8,684	0	0	0	7,043	0	0	0	0	0	0	0	0	625	0	0	38,885	8,390	63,627
Omaha	NO REPORT																		
Pine Ridge	41,614	0	0	1,797	36,871	0	7,727	0	0	0	0	0	0	30,701	67,289	0	577,333	22,579	785,911
Ponca	NO REPORT																		
Rapid City	6,201	0	0	0	0	12,947	0	0	0	0	0	0	0	9,189	3,032	0	188,474	2,451	222,294
Rosebud	17,906	0	0	0	13,347	0	0	0	0	0	0	0	0	5,801	19,218	0	549,572	18,304	624,148
Sac & Fox	NO REPORT																		
Sisseton	3,230	0	0	1,175	18,891	0	0	0	0	0	0	0	0	1,269	0	0	212,466	15,093	252,144
Standing Rock	12,689	0	0	1,583	23,046	0	2,352	0	0	0	0	0	0	1,040	15,818	0	282,211	14,551	353,290
Trenton	NO REPORT																		
Turtle Mountain	18,560	0	0	0	0	0	0	0	0	0	0	0	0	36,007	17,632	0	584,284	36,623	693,106
Winnebago	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12,293	0	110,257	15,468	138,018
Yankton/Santee	3,177	0	0	0	2,865	0	0	0	0	0	3,562	0	0	9,912	11,684	0	95,903	0	127,103
TOTAL	143,211	0	0	4,555	145,692	13,540	10,079	0	0	0	6,410	0	0	110,953	155,474	19,965	3,229,471	145,411	3,984,761

CONTRACT HEALTH CARE

TOTAL DOLLARS EXPENDED FOR INJURIES

FY97

Injury Type / Service Unit	Motor Vehicle	Water Transport	Air Transport	Accid. Poisoning	Accidental Falls	Fires/Flames	Env. Factors	Stings/Venoms	Animal Related	Drown/Submer.	Cut/Piercing Obj.	Firearms	Machinery	Suicide Attempts	Assaults	Battered Child	Undetermined	Other Causes	TOTAL
Crow Creek	6,917	0	0	0	3,426	0	0	0	0	0	0	0	0	4,501	9,779	0	78,106	8,784	111,513
Cheyenne River	12,499	0	0	0	6,111	0	0	0	6,080	0	0	0	0	16,120	37,894	0	148,965	6,685	234,354
Flandreau	NO REPORT																		
Ft. Berthold	0	0	0	0	11,572	2,556	206	0	0	0	0	0	0	1,309	5,807	0	426,209	9,075	456,735
Ft. Totten	7,473	0	0	0	4,300	0	0	0	0	0	0	0	0	2,440	8,496	0	175,658	0	198,367
Lower Brule	1,850	0	0	0	3,424	0	0	0	0	0	0	0	0	2,542	0	0	79,906	3,447	91,168
Omaha	NO REPORT																		
Pine Ridge	51,516	0	0	0	40,035	32,057	3,739	0	0	0	0	0	0	6,240	68,771	0	716,828	35,021	954,206
Ponca	NO REPORT																		
Rapid City	5,232	0	0	0	30,035	0	0	0	0	0	0	0	0	9,373	16,133	0	229,058	8,774	298,606
Rosebud	14,313	0	0	0	13,665	0	0	0	0	0	0	0	0	40,272	11,980	0	369,781	1,846	451,857
Sac & Fox	NO REPORT																		
Sisseton	5,770	0	0	0	2,695	0	0	0	0	0	0	0	0	5,310	0	0	175,911	0	189,686
Standing Rock	48,317	0	0	3,615	14,589	0	0	0	0	0	0	0	0	4,527	0	0	378,798	5,057	454,902
Trenton	NO REPORT																		
Turtle Mountain	13,275	0	0	0	17,376	0	0	0	0	0	0	0	0	0	21,733	0	712,681	8,101	773,166
Winnebago	1,550	0	0	1,205	17,817	0	0	0	0	0	0	0	0	0	0	0	43,678	3,886	68,136
Yankton/Santee	0	0	0	4,815	0	0	0	0	0	0	0	0	0	12,336	4,971	0	141,699	3,059	166,881
TOTAL	168,712	0	0	9,635	165,045	34,613	3,945	0	6,080	0	0	0	0	104,970	185,564	0	3,677,277	93,736	4,449,577

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

FORT TOTTEN SERVICE UNIT

CONTRACT HEALTH CARE

	FY 1996	FY 1995	FY 1994	FY 1993
Motor Vehicle	1	5	2	2

EXTERNAL CAUSE OF INJURY (OUTPATIENT)

	FY 1996	FY 1995	FY 1994	FY 1993
Motor Vehicle	43	56	30	28

CHS Costs

Motor Vehicle Costs for 1994	38,141
Motor Vehicle Costs for 1995	30,537
Motor Vehicle Costs for 1996	5,372

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandu

Date October 21, 1998

From Area CHS Assistant

Subject FY 1998 Trauma Information

To John Weaver – Office of Environmental Health

The information for FY'98 Trauma Cases is listed below. All information was extracted from the Catastrophic (CHEF) Cases submitted to our office from the Service Units & Tribal Facilities.

Total Number of '98 Catastrophic Cases - - - - - - 177
Total Number of '98 Trauma Cases - - - - - - 32
Total Dollars Available from Hdqtrs. - - - - - - $12 Million

TYPE OF TRAUMA (Dx.)	CAUSE	NO.	S.U.	COSTS
Skull Fracture	Fall	1	PR	$ 26,184
Fracture of the Spine	Fall	1	Macy	26,062
Severe Head Injuries	Assault	5	PR	205,875
Severe Head Injury	Assault	1	Belcourt	60,041
Multiple Fractures	Assault	1	Rapid City	136,681
Multiple Fractures	Assault	1	Newtown	24,073
Severed Artery/Stab Wounds	Assault	1	Pine Ridge	46,261
Open Abdominal Wound	Gunshot	1	Newtown	25,000
Brain Damage	Suicide	1	Fort Yates	24,200
Severe Head/Cranial Injuries	MVA -	2	Eagle Butte	73,724
Severe Head/Cranial Injuries	MVA	1	Rapid City	51,556
Severe Head/Cranial Injuries	MVA	1	Sisseton	98,174
Severe Head/Cranial Injuries	MVA	1	Belcourt	32,408
Multiple Fractures	MVA	9	Pine Ridge	119,980
Multiple Fractures	MVA	3	Rosebud	65,038
Multiple Fractures	MVA	1	Flandreau	152,417
Multiple Fractures	MVA	1	Wagner	63,144
	TOTAL:	32		$1,230,818

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

NORTH DAKOTA & NATIVE AMERICAN FATALITIES

YEAR	TOTAL FATALITIES	NATIVE AMERICAN FATALITIES	%
1990	112	19	16.9
1991	94	23	24.5
1992	88	11	12.5
1993	89	12	13.4
1994	88	20	22.7
1995	74	12	16.2
1996	85	20	23.5
1997	105	21	20.0
1998	111	19	17.1
TOTAL	**846**	**157**	**18.5**

Information provided by North Dakota Department of Transportation.

1990 Census in North Dakota, Native Americans comprise 3% of the population.

Spirit Lake Tribe-Chairman Phillip "Skip" Longie

Glossary

Age Adjustment The application of the age specific rates in a population of interest to a standardized age distribution in order to eliminate the differences in observed rates that result from age differences in population composition. This adjustment is usually done when comparing two or more populations at one point in time or one population at two or more points in time.

Area A defined geographic region for Indian Health Service administrative purposes. Each Area Office administers several service units.

Cause of Death For the purpose of national death statistics, every death is attributed to one underlying condition, based on information reported on the death certificate and utilizing the international rules for selecting the underlying cause of death from the reported conditions.

Contract Care Services not available directly from Indian Health or tribes that are purchased under contract from a community hospitals and practitioners.

Intentional Injury A type of injury that occurs with purposeful intent.

Life Expectancy The average number of years remaining to a person at a particular age and is based on a given set of age-specific death rates, generally the mortality conditions existing in the period mentioned.

Race On death certificates, race is usually recorded by the funeral director who mayor may not query the family members of the decedent. The race of a newborn does not appear on the birth certificate. In this report if either the mother or father, or both parents were recorded as American Indians or Alaska Native on the birth certificate, the birth is considered as an American Indian or Alaska Native.

Service Unit The local administrative unit of Indian Health Service.

Unintentional injury A type of injury that occurs without purposeful intent.

Years of Potential Life Lost (YPLL)

A mortality indicator which measures the burden of premature deaths. It is calculated by subtracting the age at death from age 65 and summing the result over all death

Sacred Child Project

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STATEMENT

OF

DEBORAH A. PAINTE, M.P.A.
PROJECT DIRECTOR
SACRED CHILD PROJECT
UNITED TRIBES TECHNICAL COLLEGE

BEFORE

THE COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

REGARDING S. 2526

INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION OF 2000

August 4, 2000

Mr. Chairman and Members of the Committee on Indian Affairs:

Good morning. My name is Deborah Painte, (Prairie Rose Woman) and I am the project director for the United Tribes Technical College (UTTC) Sacred Child Project and a member of the Three Affiliated Tribes (Mandan, Hidatsa and Arikara Nation) of the Fort Berthold Indian Reservation in North Dakota. I would like to thank the committee for providing me an opportunity to present testimony on S.2526 to reauthorize the Indian Health Care Improvement Act and to also welcome you to North Dakota and United Tribes Technical College.

I would like to preface my remarks, by first providing you a brief overview of the UTTC Sacred Child Project. The project is funded by the Department of Health & Human Services, Center for Mental Health Services (CMHS) under the children's mental health initiative for youth with Serious Emotional Disturbances (SED). We will soon be entering our fourth year of grant funding of this five year demonstration project. The project serves Native American children on the four reservations in North Dakota and the Trenton Indian Service Area (TISA).

United Tribes Technical College has partnered with the Spirit Lake Tribe, Standing Rock Sioux Tribe, Three Affiliated Tribes (Mandan, Hidatsa, & Arikara), Turtle Mountain Band of Chippewa and the governing body of the Trenton Indian Service Area (TISA) to develop a **System of Care** (SOC) for our tribal youth who are experiencing difficulties in their home, schools and communities. In 1993, the North Dakota state legislature commissioned a study by the Child Welfare League of America to assess the status of children in North Dakota. Not surprisingly, the statistics identified Native American youth as being highly over-represented in many of the most

restrictive settings. While Native American youth comprise 7% of the child population in North Dakota, between 30 - 45% of Native Youth were in state foster care, group homes, youth correctional center, juvenile justice system, adolescent psychiatric and substance abuse treatment centers.

These alarming statistics led to a collaborative effort between the tribes and State of North Dakota to address the complex needs of Native American youth and families. Many good things have resulted in our efforts, North Dakota tribes now receive Title IV-B administrative cost reimbursement funds for the provision of child welfare services to Medicaid eligible children through an agreement with the state; each tribe has empowered the creation of a tribal planning body for children services on the reservations called the Tribal Children Services Coordinating Committees (TCSCCs), and the four tribes and TISA have partnered to create the Native American Children & Family Services Training Institute which provides foster parent training, child welfare training and most recently, community training on System of Care and the Wraparound process.

The Sacred Child Project in its quest to develop a new System of Care for ND Native American children has faced multiple challenges and obstacles at times. But more importantly, it has overcome many of theses daunting obstacles and has demonstrated remarkable outcomes for our children and families who are enrolled in the wraparound process in the limited time we have been in operation. The System of Care philosophy and values have been embraced by many of the families as well as the numerous services providers from the various reservation systems, who in the past worked independently of one another in providing services to the same families.

A System of Care is when all of the independent child and family service systems in a community come together with the family and their natural supports systems, in order to provide better and comprehensive planning for children with mental health challenges. The empowerment of children and families in their own healing and the inclusion of the natural support systems of families, such as culture, spirituality, extended families, traditional social structures such as clans, tiospayes, societies, etc. is what sets this apart from what is happening in current mental health practice. The wraparound process is the bridge between professional services and natural supports of the family. This is what makes it work for our communities. The interventions, therefore, are creative, individualized and tailored to meet the complex needs of the child and family; rather than being a service driven system.

The elements and values of a System of Care are as follows:

- Community based
- Individualized & Strength-based
- Culturally-competent
- Families are partners
- Team driven
- flexible funding
- Balance of formal and natural supports/services
- Unconditional committment
- Collaborative
- Outcomes are measured

Local reservation providers have provided excellent local leadership, collaboration and participation ranging from child welfare, domestic violence, substance abuse treatment & prevention, juvenile justice, law enforcement, mental health and education, tribal college personnel to name a few. They are employed by the Tribes, IHS, BIA, state and private non-profit organizations. They have partnered with families and community members which has resulted in

greater choice and voice for tribal families.

The Sacred Child Project is currently working with 123 youth and their families from the five service sites. Each North Dakota tribe has prioritized how the wraparound process would best fit in their communities and local Sacred Wraparound operations are contracted and admintered by the various entities such as at Spirit Lake Tribal Court, Turtle Mountain Child Welfare, Three Affiliated Tribes Social Services, Standing Rock Health Department and TISA 638 tribally-contracted clinic. Each tribal site is slowly evolving how wraparound will best fit in their communities.

The following are the socio-economic characteristics of the youth and the families that are enrolled with the Sacred Child project

Youth guardianship: single parent - 44%; both parent parents - 15%; parent & stepparent - 11%, relative 14%; tribal custody - 13%; state custody - 3%

Youth ages: 4 - 11 years old - 15%; 12 - 15 years old - 61%; 16 - 18 yrs old - 24%

Youth Referral sources: Family members - 45%; Social Services - 22%; tribal court - 12%; School - 10%; Substance Abuse Services - 5%; Health/Mental Health - 4%; Foster parents - 1%; and self (youth) - 2%

Out of the enrolled children, there are 46% with a formal SED diagnosis.

Primary Diagnosis: Attention Deficit Hyperactivity Disorder (ADHD) - 42%; conduct-Related - 21%; Depression/dysthyma - 21%; substance abuse addiction - 5%; learning disability - 5%; and other 8%.

Of those with formal diagnosis, 79% have a secondary diagnosis.

Secondary Diagnosis: conduct disorder - 21%; ADHD - 16%; depression - 11%; substance Abuse - 5%; learning disability - 3% and other - 23%.

Of all of the ND tribal children enrolled in the wraparound process, 34% were involved with the mental health system; 34% were involved in the juvenile justice system and 37% had severe challenges in the school system and were in danger of dropping out or being kicked out of school.

The System of Care and Wraparound process being implemented and demonstrated in North Dakota Native American communities holds great promise as a model for Indian Country. Not because of what the Sacred Child Project has developed, but because a System of Care allows communities to identify their own solutions and to integrate their natural strengths into helping families. The Sacred Child Project does not hold the answers for other tribal communities, each tribal community holds the answers themselves. They know their communities, their culture and their people. The System of Care concepts facilitates using those strengths.

The System of Care and wraparound process can be adapted to fit our Native American communities because it so strongly mirrors our traditional values and structures. Western clincial models have limited success in native communities because they are culturally incongruent with our traditional values and social structures. It is not enough to add a cultural component to clinical services. The Sacred Child Project's foundation for our System of Care is our native culture. ***"It is not how culture will be integrated into clinical services, but how clinical services will be integrated into our culture."*** This basic premise and return to our own cultural foundations has resulted in better outcomes for the children who are enrolled in the Sacred Child Project.

The model is collaborative, strength-based, culturally-competent, family-focused, team-driven and can be individualized to meet the many complex needs of the children and family. While it has shown great promise there are many barriers to it's effective implementation and our ability to sustain the system infrastructure and processes we have developed.

Therefore, it is with great hope and optimism that I submit this testimony in support of the amendments and reauthorization of the Indian Health Care Improvement Act. My comments and recommendations will be made specifically in regards to **Title VII - BEHAVORIAL HEALTH PROGRAMS** with additional comments to other titles and sections of the act and are based on direct experience and knowledge of the Sacred Child project and the successful healing journeys of native children in North Dakota.

Section 701. Behavioral Health Prevention and Treatment Services

In this section, many of the provisions would facilitate the development of a comprehensive system of care; however, it is not broad enough in its scope. Under the purpose, a statement should be added that would **encourage and promote the development of a comprehensive system of care that would also include domestic violence, education, juvenile justice**, in addition to those already mentioned. There are so my complex issues that tribal families face, that all of the key child and family service agencies need to be involved; otherwise key life domains are missed and factors that impact the emotional and behavioral well-being of children are not addressed. Under the System of Care wraparound plan of care that is developed in partnership with the team, the plan of care focuses on (12) life domain areas of housing, family, social, behavioral, educational, safety, legal, health, spiritual, cultural, financial and crisis. At each child support team meeting, the

professional and natural supports of the child, partner with the family to identify possible interventions and resources to address these issues. This comprehensive planning is family driven.

Under section 701(a)(4) multi-disciplinary resource teams **specific mention of the inclusion of families and the natural supports of the family should be made.** It has been Sacred Child Project's experience that without specific and active inclusion of the family and the natural support systems, service providers tend to push the services provided by their agency; whether it meets the needs of the child or not. The SOC should be needs-driven rather than service driven. This does not mean that clinical and professional services are not welcomed, but rather support for children needs to include all healing interventions. Children and Families need to have ownership of the plans and intervention strategies that are implemented; otherwise, you may or may not get their follow through on the plans. The plans need to be reflective of family culture as well. What works well for one family, may not work for another. The inclusion of the natural support systems is paramount as well. This it what allows for the creative and dynamic development of interventions and solutions. The well-rounded team composition is what makes the wraparound process work. It also reduces the duplication of services and enhances cross agency communication and collaboration. Providers involved with family can dovetail their efforts with others in the community.

Under section 701(c)(1) **there needs to be specific mention that services provided under a comprehensive continuum of care be culturally-appropriate.** It has been our experience that some mainstream clinical practices and services are not appropriate for families who still retain and

practice their traditional lifeways yet it is forced upon them if they want to seek help for their children. **Under the services section, transitional living should be changed to transitional services** otherwise it is too narrowly focused. There is much more to helping a youth transition back into the family and community than just living environment. Additionally by focusing just on treatment or recovery goals, you miss a key target population of youth that need behavioral health services. These are the youth who are returned from foster care, group homes, and the juvenile justice system. They have a lot of trauma and emotional/behavioral issues they have to deal with and transition can mean not only back into the family, but we have also found that transitional services are needed for adjusting back into the community. **Prevention services need to be provided up to at least age 14 years old.** We have found that at ages 12 - 14 years, critical life style decisions are being made at this time. There are also two critically needed services that are missing from this continuum of care provision. **Respite care and mentor services should be included.**

Many times, the family stress due to the child's mental health and behavioral challenges creates a burden that some families are unable to bear so they eventually give up on the child and allow the child to be placed in long-term placement and treatment. When the child returns, the family may still be unable to deal with these pressures and eventually the child ends up in out of home placement again. This legislation needs to help families and children stay together and provide the services and supports they need to deal with the issues in their home communities. Otherwise it just delays the issue. Sometimes all a family needs is a brief, temporary break from these pressures so they can regroup so they do not give up on the child. When adults don't know what to do for a child, there is a tendency to send the child away rather than to try things that may be unique and different from the way they normally provide services. We have also found that

mentors also provide a key support for the child and family. Because many of the youth may live in a single parent home, the mentor can provide an additional caring adult and positive role model for the child. At the Sacred Child project, young adult mentors and cultural mentors have done more to help some children than any other clinical service.

Lastly, the continuum of care should include flexible wraparound funding for individualized services not necessarily identified under the stated services. This is critical to ensuring a needs-driven system otherwise all you are doing is trying to fit the youth into the design of program services rather than what the child really needs to function well in their home, school and community.

Section 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF INTERIOR

Under Section 702 (b) SPECIFIC PROVISIONS there should be another provision added. This new provision (4) would require the Bureau of Indian Affairs to make an assessment of current administrative program and funding regulations that inhibit or prohibits comprehensive planning and services for community based services that will allow the child to remain at home and with their families. Currently, the Bureau has spent millions of dollars in sending children to substance abuse treatment and long-term residential placements in group home and juvenile detention centers, etc.; but yet does not allow for these same funds to pay for community based services that would allow for treating the child at home. We have found that providing community-based supports and services is just as effective if not more effective in positively impacting the child's behavior. It is also more cost-effective. These out-of-home placements costs can reach into thousands of dollars, yet providing a mentor, group activities,

ntensive cultural guidance, etc. can cost far less and more youth can be helped. We have also found that unless community based services are an option for the child returning from these placements, the behaviors that led to their being placed out of the community usually manifests itself within a few weeks if not the same day.

SECTION 703.COMPREHENSIVE BEHAVORIAL HEALTH PREVENTION AND TREATMENT PROGRAM

Under Section 703. (a)(1) A statement should be included that states that a comprehensive system of care will be encouraged and promoted. System of Care philsophy, values and concepts would benefit all populations and training should be provided to all services providers. The Turtle Mountain Band of Chippewa has mandated all program directors to receive training in System of Care and wraparound. This is exciting because true systems change can only occur when everyone understand what needs to be done and are empowered to do so.

SECTION 707, INDIAN YOUTH PROGRAM

Section 707 (c)(1) Additional services and supports that should be added to this section are wraparound process, care coordination more commonly known as case management, and mentoring.

TRAINING, MANAGEMENT INFORMATION SYSTEM & RESEARCH ISSUES:

It cannot be emphasized enough that training and education on system of care be available on a whole scale basis for tribal groups who are interested. The Center for Mental Health Services have

limited funds to provide circle of care planning grants to tribes. There are only (8) tribal projects that are Native American CMHS service grantees out of (44) across the nation. Systems change is necessary to improving services provided to tribal children and families. Sacred Child Project is also working with the Tribes of North Dakota and the Native American Children & Families Services Training Institute to develop a comprehensive Management Information System (MIS) for children & family data. The task in itself is monumental. We have learned and we have found that even with the best MIS system developed unless you have the hardware, technology, training and manpower it will not be effective. This legislation should look at providing funding for training and education for tribal people who will be working with MIS and data issues at the local level. It is important to have not only people who provide direct behavioral health services, but also tribal staff who will have the ability to collect and analyze if the services being provided are effective in terms of healing and financial costs. The MIS should also be collecting data beyond the Service and the Bureau of Indian Affairs operated programs. It should also include tribally-operated programs such as 638 contracted programs, state and private funded programs who are providing services to tribal communities to get a true and accurate picture of what is happening or not happening.

The Sacred Child Project is also undertaking its own research and evaluation efforts. We have had to start from the ground up. Rather than contracting out to the a large university, we are beginning to train our own staff and develop our own local capacity. Tribal colleges can play a key role in developing this much needed capacity. Research in tribal communities is better served by having our own tribal people involved in all aspects of research. We do not view research from a strictly isolated viewpoint of crunching numbers. What is appropriate and acceptable to the

mainstream may not be appropriate for tribal communities. Research is only valuable when the findings can be use to positively affect real life practice.

CONCLUSION

In conclusion, I want to state that S.2526 can continue to make monumental changes in the health care provided in Native American communities, as it first did in 1976. Sacred Child Project has reaped many of those benefits, since North Dakota tribes are now accessing Medicaid dollars for children's mental health services provided by tribally-employed Sacred Child staff. It is my hope the Senate Committee on Indian Affairs will favorably consider the above recommendations so the door to true systems change can be opened and will lead to better outcomes for children and families. Rather than holding fast to the notion that clinical services are the only way to help families, we need to integrate natural community and family supports in the healing process.

At Sacred Child Project we have begun the process of changing paradigms, attitudes and the way we work with our own people. We do not blindly accept that we do things a certain way because this is how the mainstream does them. We take what is good and leave the rest, which is what the great spiritual leader of the Lakota people, Sitting Bull, urged his people. His words still hold great truth even to this day.

Again thank you for allowing me to provide information and comments relating to the Indian Health Care Improvement Act Reauthorization. I welcome any questions and comments you may have.

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TESTIMONY OF EVERETTE L. ENNO
Chairman of the Aberdeen Area
Tribal Chairmens Health Board
Reauthorization of the Indian Health Care
Improvement Act, P.L. 94-437

United States Senate
Committee on Indian Affairs
August 4, 2000

Good morning Senator Dorgan, Senator Conrad, and other members of the Committee.

Thank you for the opportunity to present testimony today concerning proposed legislation reauthorizing the Indian Health Care Improvement Act. My name is Everette L. Enno and I am Chairman of the Aberdeen Area Tribal Chairmens Health Board and the Trenton Indian Service Area. The Indian Health Care Improvement Act, in its draft form, is being proposed for a period of twelve (12) years. The proposed bill is one of the most comprehensive to date for the health care of our Indian people. It is very important that Congress understands the issues, concerns, and complexities of the Aberdeen Area Tribes when discussing and including the recommendations that will become a part of the final legislation.

The Aberdeen Area Tribal Chairmens Health Board is comprised of seventeen (17) Tribes, a tribal health board, and a tribal organization. All of the Tribes/tribal organizations in the Aberdeen Area, except for two Tribes, provide health care services directly or through contracting. The total user population of the Aberdeen Area Tribes is approximately 113,000 tribal members. All of the Tribes within the Aberdeen Area continue to receive services through the previous negotiation of treaties with the U.S. Government.

I know a lot of work by many organizations, steering committees, and individuals has been done in the preparation of the draft legislation. I would be remiss if I did not take the time to acknowledge and support all of the effort that has gone into the draft bill. There have been many local, regional, and national consultation meetings with Tribes, Indian Health Service, and other agencies that deal with the health care of our Indian people. As a Tribal leader, I have not seen so many other agencies involved in the arena of health care as I have these past two years. That kind of commitment and involvement from all of these agencies and interested parties can only lend itself to the creation of

legislation that will finally start to address the health care disparities and needs of our Indian people.

The draft bill, in it's present form, is an excellent document and very comprehensive in nature. There are some health care issues and concerns of the Aberdeen Area Tribes, however, that I feel need to be discussed and incorporated into the final version of the Indian Health Care Improvement Act. The testimony I am about to present will focus on those health care issues.

One of the most important, but seldomly used, factors in determining the distribution of health care funds is health status. The Aberdeen Area Tribes, by and large, have the worst health status of all areas when all of the chronic illnesses are taken into consideration. The Aberdeen Area Tribes rank at or near the bottom in the areas of infant mortality, morbidity, rates of heart disease, rates of diabetes, alcoholism, substance abuse, rates of cancer, etc. Those are only a few of the statistics that remain a constant in the Aberdeen Area. As our tribal population continues to increase, so does the rate of adverse health status factors. A primary concern to the Aberdeen Area Tribes is the distribution methodology for health care funding. It would only seem reasonable and prudent that more health care funds be distributed to those areas that have the lowest health care status. It has always been known and understood that the mission statement of Indian Health Service is **"to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level."**

The Level of Need Funded Study, which was completed in December of 1999, is an excellent base for determining the distribution of funds for all Tribes. In the final analysis, however, the study does not properly factor in health status, wrap-around services, distance and isolation, etc. If the goal of Indian Health Service is to raise the health status of Indian people to the highest level, then it should start with a distribution methodology that will allocate more funds to those areas that have a demonstrated need. If the Level of Need Funded Study is going to be used as a document for the national distribution of funds, then it needs to be revised to serve its intended purpose. That is, to allocate funds on the basis of ensuring an adequate level of health care for all of our Indian people.

The issue of Contact Health Service is very important to the Aberdeen Area Tribes. At the present time, the Aberdeen Area receives approximately $ 42 million in Contract Health Service funding. There is a need for at least $ 100 million, resulting in an unmet need of $ 60 million. If the other eleven (11) area offices are factored into the unmet need equation, I am sure the total amount of Contract Health Service funds that is needed by all Tribes is close to a $ 1 billion. Of particular concern to the Aberdeen Area Tribes is the proposal to create Contract Health Service dependent areas. These areas, without the benefit of a Federal presence, would receive a weighted formula in the distribution of funds. The Aberdeen Area Tribes do not support this proposal due to the fact that all Tribes across the nation have a need for additional Contract Health Service funds regardless of

location or access to health care facilities. Most or all of the Aberdeen Area Tribes expend their Contract Health Service budgets prior to the end of the contract year. Tribal members from outside the service delivery area are accessing Contract Health Services, which in turn has put a strain on existing budgets. In many cases, most of our Indian people will not seek the additional medical attention if they know the bill is not going to get authorized for payment. The end result is that the medical condition of the client gets worse for lack of access and treatment. The subsequent medical cost for that client also increases as the medical condition has gone from fairly routine to possibly serious.

Another area that needs to be addressed is the Catastrophic Health Emergency Fund. At the present moment, the Tribes must pay the first $ 20,100 of a medical bill in order to access CHEF funding. One of the proposals being considered is to allocate CHEF funds at the area level for administration to the Tribes. That proposal, however, still does not address the "threshold" that Tribes must pay in order to access the program. The Aberdeen Area Tribes would like to see the threshold reduced by 50% from $ 20,100 to $ 10,000, and still allow the area offices to administer and allocate the funding to the Tribes. In the Aberdeen Area alone, CHEF cases for FY 2000 totaled $ 2.2 million. The reimbursement on those CHEF cases to the Tribes totaled $ 960,000.

An important initiative that was started a few years ago that needs to be supported and continued by Congress is Healthy Start. Healthy Start has made a positive impact in the Aberdeen Area by reducing the rate of infant mortality by almost 50%. The program has done wonders for our young mothers and infants. Even though the mortality rate has decreased significantly in the Aberdeen Area, it is still much higher than the rate for the general population. All of this means that much more work needs to be done in order to bring down the mortality rate to an acceptable level. At the present time the Northern Plains Healthy Start, an Aberdeen Area tribal initiative, is funded on a competitive basis through HRSA. For continuity purposes, the Aberdeen Area Tribes would like to see Healthy Start as a permanent funded line item under the Maternal Child Program of Indian Health Service. The Aberdeen Area Tribes would like to see the Northern Plains Healthy Start program funded according to the historical funding base and additional appropriations be made available for other Tribes that may want to start up their own programs. The current proposal is to create a permanent funding line item under Maternal Child Health but to allow the program to be administered via Block Grants by the States. This proposal may not be in the best interest of the Tribes as some States have demonstrated an unwillingness to work with the Tribes in any way, shape, or form.

An important part of this draft legislation that needs to be considered is the process of negotiated rule making. In the past, there have many instances where Tribal leaders have not been involved in the initial drafting of the legislation or the subsequent amendments to the legislation. The Indian Health Care Improvement Act is very broad and comprehensive. Once the legislation is passed, from time to time amendments will be needed to either broaden or expand the current range of services or

authority within the Act. As a means of addressing the possible amendments, the Aberdeen Area Tribes would like to see a negotiated rulemaking process become a part of the final legislation. The negotiated rulemaking process should ensure tribal consultation and participation from all forms of health care delivery on each and every amendment. The majority of the negotiated rulemaking committee should be comprised of Tribal leaders. With Tribal leader involvement, the Tribes will continue to have a voice in the on-going development of the health care delivery system.

Senator Dorgan, Senator Conrad, and other committee members, the Aberdeen Area Tribes as well as many Tribes across this great nation, continue to provide health care services to our Indian people comparable to a Third World country. In an era of current and projected budget surpluses, this is totally unacceptable for our Indian people. The only way to address the current crisis of health care in Indian country is to allocate additional resources.

Our Indian people negotiated treaties, ceded millions of acres of land and natural resources, fought and gave up their lives for this great nation, all in good faith. From one sovereign nation to another, it is time for the United States Government to acknowledge and address the trust responsibility it has towards the Indian people of this great country. On behalf of the Aberdeen Area Tribal Chairmens Health Board, I would like to personally thank Senator Dorgan, Senator Conrad, and the other committee members for holding this field hearing and for allowing me to present this testimony today.

TESTIMONY OF ANDREW J. GREY, SR.
TRIBAL CHAIRMAN
SISSETON-WAHPETON SIOUX TRIBE

At the Legislative Field Hearing
Held by the
Senate Committee on Indian Affairs

REGARDING S. 2526
TO REAUTHORIZE THE INDIAN HEALTH
CARE IMPROVEMENT ACT
TITLE VII. BEHAVIORAL HEALTH PROGRAMS
TITLE VIII. MISCELLANEOUS

BEHAVIORAL HEALTH AND QUALITY OF LIFE IN INDIAN COUNTRY

PRESENTED AT:
James Henry Community Center – Small Gymnasium
United Tribes Technical College
Bismarck, North Dakota

August 4, 2000

BEHAVIORAL HEALTH AND QUALITY OF LIFE IN INDIAN COUNTRY

Thank you Senator Dorgan and members of the Senate Committee on Indian Affairs for this opportunity to testify on reauthorization of the Indian Health Care Improvement Act and, specifically, on the behavioral health section of this legislation. It is fitting that the field hearing on Title VII. BEHAVIORAL HEALTH PROGRAMS, should

be held in the Aberdeen Area, which has the most deplorable lifestyle-related statistics in the Nation and perhaps the world.

Quality of life can be measured in two statistics: infant mortality and life expectancy. Unfortunately, the Aberdeen Area continues to lag behind the other I.H.S. Areas and U.S. all Races in these and other measures. Life expectancy in the Aberdeen Area is eleven years less than for other Americans, due in large part to high rates of alcoholism, trauma, suicide, homicide, and cancer - all of which are related to behavior and lifestyle. The infant mortality rate for Indians in this Nation is 22% higher than for U.S. All Races, according to the *Regional Differences in Indian Health 1998-1999* publication published by the Department Heath and Human Services. The Aberdeen Area's infant mortality rate is 86% higher.

There is an aversion to discussing behavioral health problems, because it's difficult to acknowledge how great these issues are in Indian Country. In the past, there has been a tendency to compartmentalize the problems into "mental health", "alcoholism", and "substance abuse", like they were separate and distinct instead of inter-related. This tendency has been reinforced by the medical model for health care adopted by the Indian Health Service, which focuses on the physical ailments, too often ignoring the social, emotional, and spiritual aspects to healing. Health statistics are only one reflection of quality of life on Indian Reservations. So, too, are other social problems, including unemployment, poverty, child abuse and neglect, domestic violence and elder abuse, crime (resulting in a disproportionate representation of Indian people in penal institutions), inadequate educational preparation, and crowded substandard housing.

It is important to stress that, for the Sisseton-Wahpeton Sioux Tribe, these problems are a result of traumatic events which have occurred to the Dakotah people in the past two hundred years, including (but not limited to):

1. Dakotah War/"Minnesota Uprising" of 1862 and resulting holocaust

2. Placement on the Lake Traverse Reservation (1867); establishment of Fort Sisseton

3. Separation of children from their families through boarding school and later foster care placements

4. Oppression from the Federal Government/dominant culture, including punishment for speaking the Dakotah language or engaging in cultural practices

5. Acculturation and civilizing policies

6. Removal of the remains of deceased Tribal members and other Indians buried on these lands to the Army Medical Museum in the east for scientific study

7. Opening of the Lake Traverse Reservation to white settlers (April, 1982) and subsequent loss of land base and means for self-sufficiency

8. Poverty, unemployment, and lack of acceptable opportunities

Indian people are strong and resilient enough to have withstood all this, but radical societal changes and trauma have taken their toll. It's important to have these reasons in perspective when discussing behavioral health problems and the resulting quality of life in Indian Country. Other Tribes have experienced similar historical trauma, as well as self-perpetuating, intergenerational cycles of dysfunction and self-destructive behaviors that are the direct result of these circumstances. The deplorable health statistics and social problems stated above are all symptoms of the underlying behavioral dysfunction that exists. The multi-disciplinary and interagency approach outlined in Section VII of S. 2526 are imperative for effectively and concurrently addressing the afflictions of body, mind and spirit that manifest themselves in the dramatic health status disparities between first Americans and the general population of this Nation.

Too often, it has been said that "throwing more money at it" won't impact the poor health morbidity and mortality rates in the Aberdeen Area. Resource allocation formulas disregard health status as an important weighted factor in distributing resources, because the prevention and treatment of behavioral health problems does not fit well into the western medical model. Also, the core benefits package that the Indian Health system is typically able to offer is admittedly inadequate, given the severe limitation of appropriations, staff, and facilities. Title VII provides several excellent and innovative funding authorities which, if carried out, could potentially close the gap and eliminate health disparities for Indian people.

The remarkable economic and community development that Tribes are undergoing is part of the solution. So are the health and social programs. Programs like Northern Plains Healthy Start are making a difference, but change takes time, particularly changes in behavior and lifestyle. For example, it has long been suspected that the high rate of Sudden Infant Death Syndrome (the leading cause of infant death in the Aberdeen Area) is lifestyle related. From 1992-1996, the Aberdeen Area Tribal Chairmen's Health Board, Indian Health Service, National Institute of Health, and Centers for Disease Control conducted a case-control study of infant mortality in the Aberdeen Area. At the May 17, 2000, Aberdeen Area Tribal Chairmen's Health Board meeting, chilling presentations were made by the principal investigator, Leslie Randall, and Dr. Hannah Kinney, the neuropathologist who analyzed the brains of the infants from the Aberdeen Area who died and compared them to the brains of infants who died in San Diego and Boston. Preliminary analysis of this very sensitive data finds correlations between Sudden Infant Death Syndrome and perinatal exposure to both alcohol and tobacco smoke. The study identified the following statistically significant risk factors associated with low brain cell myelination in the infants that died:

- # of drinks per day in three months prior to pregnancy
- # of cigarettes per day in the 1st and 3rd trimesters
- # of hours per day the baby was exposed to tobacco smoke after birth

It is important to point out that these infants who died of SIDS did not have Fetal Alcohol Syndrome. The effects were more subtle, having to do with retarded development of the myelin sheaths around the axons of neuron cells in the brain. (Myelin is composed of four lipids, and its formation is nutrition-related.) The number of days per month that the mother drank in the three months prior to pregnancy is related to all four myelin measurements (the more drinking, the lower the myelin measurements after adjusting for age). It is also suspected that there is an increase in brainstem nicotine receptor binding in SIDS cases exposed to intrauterine cigarette smoke. However, the study was not conclusive, because the smoking prevalence was as high for the control cases as for the SIDS cases. The results of this study are to be published in two professional journals this year. It appears that SIDS, as well as Fetal Alcohol Disorders, can be prevented by modifying behavior

(specifically abstinence from alcohol and tobacco before, during, and after pregnancy by both the mother and her partner).

There is need, then, for more behavioral health research of this nature in Indian Country (as provided in Section 713 of S. 2526), as well as for the prevention, intervention, and treatment programs described in Title VII. as proposed.

The Sisseton-Wahpeton Sioux Tribe, along with several other Plains Tribes, is participating in an important research project that is being conducted by the University of New Mexico Center on Alcoholism, Substance Abuse and Addictions (UNM-CASAA) through funding from the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The principal investigator, Dr. Philip May, is world renowned for his work in Fetal Alcohol Syndrome. Phase I of this research was to get information on patterns of drinking and non-drinking in Indian communities on the Plans through a random sample survey. Todate, UNM-CASAA has tabulated the results from 1,444 surveys on four Indian Reservations, including 372 Sisseton-Wahpeton. (They have not completed the data entry, however.) Drinking prevalence (percent of respondents indicating they drank alcohol in the past 12 months or 30 days) is virtually identical to national norms. Abstinence is the usual behavior for Indian people. However, this research suggests that, for those who do consume alcohol, binge drinking among Indians is higher than national norms. Binge drinking by definition is five or more drinks at a time. It is the manner in which these persons drink that sets up the problems. The following two tables describe the data that has been tabulated so far in the Fetal Alcohol Syndrome Epidemiological Research Project.

PRELIMINARY DATA ON DRINKING BEHAVIOR AMONG PLAINS INDIANS IN THE PAST 30 DAYS BY PERCENT (Sample N = 1,444)

BEHAVIOR	Males	Females
Abstinence - *Usual Behavior*	40.9%	60.5%
Drinkers	59.1%	39.5%
Occasional (1-9 days)	(45.2%)	(34.9%)
Regular (10-19 days)	(7.7%)	(3.1%)
Heavy (20-30 days)	(6.1%)	(1.5%)

PRELIMINARY DATA ON BINGE DRINKING IN PAST 30 DAYS FOR PLAINS INDIANS BY PERCENT (Sample N = 1,444)

BEHAVIOR	Males	Females
No binge drinking -	52.4%	75.4%

Usual behavior		
Binge Drinkers	**47.6%**	**24.6%**
Occasional (1-4 days)	(29.3%)	(12.5%)
Regular (5-9 days)	(10.4%)	(9.6%)
Heavy (10-30 days)	(7.9%)	(2.5%)

This data indicates that the 12% of females who are regular or heavy binge drinkers are who needs to be targeted for Fetal Alcohol Disorder prevention and intervention services. There is also need to educate young people regarding drinking behavior, inasmuch as when respondents were asked their opinion on how many drinks are needed to get drunk, the majority thought it took seven or more drinks!

It is significant, also, that 67% of the binge drinkers in the total sample reported having been involved in a car crash, closely followed by 64% who report that they frequently fight when drinking. These are the individuals most likely to contribute to the high mortality rates for injuries and homicide. In addition, fifty-two percent (52%) of the total 1,444 respondents had experienced alcohol-related deaths in their immediate families from motor vehicle crashes, cirrhosis of the liver, alcoholic psychosis, DTs, homicide, and suicide (most often citing loss of uncles, brothers, cousins, and fathers through these tragic events).

Earlier this year, the University of New Mexico was funded for Phase II of this research project, which is to implement five-year clinical prevention trials in the same Indian communities where the baseline studies were done. In addition to the alcohol prevalence study, diagnostic dysmorphology clinics were held to determine the incidence of Fetal Alcohol Syndrome, Partial Fetal Alcohol Syndrome, and Fetal Alcohol Disorders among Plains Indians. At the end of the five-year "intervention" period, the UNM-CASAA will request funding to repeat the alcohol prevalence survey in order to compare or measure "progress". The dysmorphology clinics will be held throughout all project phases. The Sisseton-Wahpeton Sioux Tribe feels very fortunate to be participating in this demonstration program because of its potentials to prevent the behavior-related tragedies that affect quality of life. There is a definite need for this work to be replicated throughout Indian Country, so the authorizations and Memoranda of Agreement provided in Title VII are essential.

At this time, I would like to direct your attention to the following table, which further illustrates the impact of behavior-

related health problems in Indian Country and the Aberdeen Area, as compared to U.S. All Races. This data is also from the *Regional Differences in Indian Health, 1998-1999* publication published by the Department of Health and Human Services.

BEHAVIORAL HEALTH DATA COMPARISONS (1994-1996)

HEALTH STATUS INDICATOR	U.S. ALL RACES	ALL I.H.S. AREAS	ABERDEEN AREA
Infant Mortality Rate(Per 1,000 live births) *The rate is 22% higher than U.S. All Races, and the Aberdeen Area is 86% higher*	9.3	7.6	14.1
Life Expectancy at Birth (Years) *The life expectancy of an Indian in the Aberdeen Area is 11 years less than U.S. all Races*	75.8	73.2	65.2
Years of Potential Life Lost *Aberdeen Area rate is more than twice as high as U.S. All Races*	53.7	91.5	127.6
Alcoholism Death Rate (Per 100,000) *Aberdeen Area rate is 16 times higher than the U.S. All Races rate and more than twice as high as the All I.H.S. Areas rate*	6.7	48.7	108.7
Accidents and Adverse Affects Death Rate (Per 100,000) *Aberdeen Area rate is four times higher than U.S. all Races*	30.5	92.6	124.4
Suicide Rate (Per 100,000) *Aberdeen Area rate is 2.6 times higher than U.S. All Races*	11.2	19.3	29.7
Homicide Rate (Per 100,000) *Aberdeen Area rate is 1.7 times higher than U.S. All Races*	9.4	15.3	16.2
Cancer Death Rate (Per 100,000) *Aberdeen Area rate is 1.33 times higher then U.S. All Races*	129.9	116.6	172.9
Indian mothers who drank during pregnancy *Aberdeen Area mothers are four times more likely to drink during pregnancy than U.S. All Races*	1.5%	4.5%	6.3%
Indian mothers who smoked during pregnancy *Aberdeen Area mothers are 2.7 times more likely to smoke during pregnancy than U.S.*	13.9%	20.4%	38.2%

All Races			
Live Births with prenatal Care Beginning in the 1st Trimester *Aberdeen Area mothers are 14.6% less likely to access prenatal care in the first trimester*	81.3%	66.5%	66.7%

Tobacco use among Indian youth presents a startling snapshot of a negative health behavior that starts at a very young age in Indian Country. Experimentation, use, and subsequent addiction to tobacco is frequently the gateway to other substances for youth. The *South Dakota Youth Risk Behavior Survey Report 1997* (conducted by the South Dakota Department of Education, Cultural Affairs and Office of Comprehensive School Health, and South Dakota Department of Human Services, Division of Alcohol and Drug Abuse) indicates that by age eleven, thirty-nine percent (39%) of Native American students indicate having smoked a cigarette. Fifty-four percent (54%) of students surveyed in grades 6-8 had smoked cigarettes on one or more of the past thirty days. Sadly, eleven percent (11%) of these students had bought cigarettes themselves in a store, and only twenty-one percent (21%) were asked to show proof of age. In addition, sixty-two percent (62%) of the respondents in grades 6-8 had used chewing tobacco.

By grades 9-12, the percent of Indian youth that smoked cigarettes on one or more of the past thirty days was seventy-four percent (74%), and fifty-two percent (52%) reported smoking on school property. The percent of 9-12th grade respondents who reported using chewing tobacco during the past thirty days was forty percent (40%). The percentage of respondents in grades 9-12 who used chewing tobacco on school property in South Dakota on one or more of the past thirty days was thirty-three percent (33%).

How can these behaviors be perpetuated in today's reality of heightened public awareness of the health risks associated with habitual use of tobacco, as well as the astronomical increases in the costs of these products? Clearly, strategies for prevention, intervention and treatment must be developed and implemented before more Indian children are lured onto the path to self-destructive behaviors and addictive lifestyles.

The Indian health care system is overburdened with catastrophic cases, which all too frequently are alcohol, tobacco, or drug related. In FY/2000, for example, the Sisseton Indian Health Service carried over a $200,000 deficit in its Contract Health

Service budget, an amount that had to be taken off the top of the current year allowance. During the past three years, thirty-seven (37) catastrophic cases consumed twenty-five percent (25%) of Sisseton's meager Contract Health Service budget (consuming $1.5 Million of the $6 Million allocated to the Sisseton-Wahpeton Sioux Tribe for referral services for this three-year period). According to the data provided by the Sisseton Indian Health Service at the request of the Tribe, the Contract Health Service Program is funded at only $445.82 per user of the I.H.S. The average amount spent per catastrophic case, in comparison, was $40,540.54. Only six, or sixteen percent (16%), of these cases accessed the Catastrophic Health Emergency Fund (CHEF) administered by I.H.S. Headquarters.

Appropriations for the CHEF has most definitely not kept pace with inflation and population growth, so the Fund is depleted well before the end of the fiscal year (requiring the costs to be absorbed by the local Service Units). As a result, the only patients with access to specialty care and treatment provided in private, tertiary facilities, such as Meritcare in Fargo, are those with conditions deemed to be "life or limb threatening". This means that patients with chronic medical problems, who may be suffering pain and a reduced quality of life, do not get treated by a specialist in a timely manner. Symptoms get treated, not the disease itself. Too often, the condition is left untreated. Example: one visit to a rheumatologist would be more cost effective than the ongoing cost of prescriptions to treat the symptoms - without the toxic effects of drugs such as Motrin (which damages the kidneys). Another example is chronic gall bladder problems (treating the pain for months until it ruptures). A third example is that by the time a patient's lupus-induced tumor was removed, secondary problems and complications had developed that were costly to treat. Also, the severity of the condition progressed from one requiring relatively minor treatment to one requiring major, life-threatening surgery.

Of the five medical priorities established by the Contract Health Service program for payment purposes, the Sisseton Indian Health Service has only enough funding to cover <u>part</u> of the Priority I category (IB-1 and IB-2). There is no longer enough money to pay for IB-3 conditions and the four categories below it. This means that followup visits to ophthalmologists and cardiologists for patients with diagnosed disorders and conditions (like diabetes and heart disease), surgeries for conditions that are chronic and debilitating but not acute at the exact moment the I.H.S. doctor sees the patient, hernia repair, psychiatric treatment, cleft lip surgery, removal of bunions and spurs of the foot . . . the list

goes on and on . . . are deferred, because the patient does not have the personal finances to pay for the services out-of-pocket. Also, the patient's view is that the I.H.S. is responsible for providing comprehensive health services to him or her from birth to death, cradle to grave, womb to tomb. Accordingly, during an eight-month period from October 1, 1999, through May 31, 2000, the Sisseton Indian Health Service deferred 462 cases. Of the 462, 127 were for eye care, 42 were for orthopedics, 23 were for cardiology, 23 were for physical therapy, and the reminder were for ENT, neurology, gynecology, urology, etc. The estimated cost of this backlog is $407,500.

Depletion of the Indian Health budget, then, is another way that behavioral health problems, including catastrophic health conditions, adversely effect the overall quality of life in Indian Country.

In view of these considerations, the new and expanded authorities for Behavioral Health Programs provided in S. 2526 are critical. Access to needed behavioral health services is inadequate. For example, the Aberdeen Area has only eighty-six (86) alcohol/substance abuse treatment beds available to serve a user population of 113,064. No alcohol/substance abuse program in the Aberdeen Area has sufficient funds to operate an open-ended program so that clients can enter treatment when circumstances motivate them to. By the time there is a treatment slot available, the window is too often passed by.

No program in the Area has the resources to offer a complete treatment continuum. This is particularly unfortunate for adolescents, who through a lack of comprehensive, onsite behavioral health and family therapy services and incentives for participation, are uprooted from their homes and schools and are placed at the regional treatment center operated by the I.H.S. on the Standing Rock Reservation for several weeks. Alternatives do not exist on the Reservations. The result is overwhelming demand for inpatient treatment services, ongoing frustration with the treatment centers' inability to meet the need, and dubious results in terms of lasting behavior change among the clientele served within the context of their families and peers.

Nor is State accreditation and, thereby, capacity to generate third party revenues necessarily the panacea. On March 17th of this year, the Sisseton-Wahpeton Sioux Tribe's inpatient alcoholism program (Dakotah Pride Treatment Center) received provisional

accreditation under the South Dakota Department of Health, Division of Alcohol and Substance Abuse Services. This was accomplished through a lot of hard work by the staff. Also, it was made possible by Tribal Government subsidizing I.H.S. contract funding through gaming proceeds to bring the facilities up to code, as well as to hire a clinical supervisor, outpatient treatment/gambling addictions counselor, administrative assistant, and billing clerk. The Tribe never intended and in all honesty can not commit to making the subsidy perpetual. Third party billing is an opportunity to generate the additional funds needed from other revenue streams. There are fifty-three (53) accredited providers in South Dakota. The State Division of Alcohol and Substance Abuse does not have contracts with all of them, however. The State paid for treatment of 17,000 people last year through the contracts it has with some (not all) of the fifty-three accredited treatment programs. The State employs the following criteria for deciding which treatment facilities they will contract with:

1. Accreditation

2. Continuum of care (Applicant demonstrates ability to offer a comprehensive package for clients, including medically-monitored inpatient, day treatment, outpatient, transitional services, and aftercare.)

3. County designation as a core agency

4. Program can/will serve a range of people (everyone - for Tribes this would include non-Indians)

5. Core agency status

In addition to contracts with the State Division, there is also potential for the Dakotah Pride Treatment Center to negotiate a provider agreement with the State Medicaid office, which would enable them to bill for services provided to youth and pregnant women. In South Dakota, 2,500 kids were treated through Medicaid last year, youth being the largest population served. Of this number, only nine percent (9%) actually needed structured treatment after they went through the State's diversion model, Primed for Life, and, for some, a thirty-hour family therapy program. The State of South Dakota has been monitoring its outcome rates and has demonstrated a 42% - 47.5% rate of adult clients maintaining abstinence one year after completing treatment by utilizing a

continuum of care model (where the client is transferred from one treatment component to another, as needed).

Although the initiative of the Dakotah Pride Treatment Center is commendable, and the State Division of Alcohol and Substance Abuse seem co-operative and willing to work with the Tribe, South Dakota political policy is something to keep an eye on. Consistently through the years, the Governor and his staff have taken the position that the Federal Government and Indian Health Service are responsible for health care on Indian Reservations and that they do not want State revenues to in any way usurp that Federal responsibility. This policy was most recently stated at a meeting the Healthy Start project had with State officials last month, wherein a State official said again that the State would be happy to pass 100% Federal Medicaid dollars through to the Healthy Start program for targeted case-management of maternity clients if the Indian Health Service bills for those services. However, I.H.S. does not have authority to bill for case-management or for services that are provided outside an I.H.S. facility. A number of years ago, the same State official made the same pronouncement at the listening council meeting with representatives from the Department of Health and Human Services in Bismarck on the issue of long term care. He stated that if the Indian Health Service builds and licenses nursing homes, the State of SD would be willing to pass 100% Federal funding (without the 33% match that comes from the State's General Fund) on as reimbursements for Medicaid-eligible clients. (Medicaid pays for the majority of nursing home bills in South Dakota and for Indian people.) Indian Health Service officials are adamant in declaring that they do not provide long-term care. Moreover, they are not funded to do so at all. The difference here with alcoholism/substance abuse treatment is that the State of South Dakota has already licensed and accredited our program. It remains to be seen, though, whether the political policy of the State of South Dakota becomes a factor when the Tribe's treatment program submits its application to be a contract provider six months from now. Will the State be willing to have funds appropriated from the State Treasury go to a Tribally operated treatment facility on an Indian Reservation? It remains to be seen.

The following challenges present in Dakotah Pride Treatment Center's quest to generate third party dollars to subsidize existing funding from the Indian Health Service:

1. Accreditation of outpatient and aftercare services for youth and adults

2. Amend scope of work in the I.H.S. Master Contract to include outpatient treatment for youth

3. Reprogramming of DPTC resources to adolescent treatment

4. Marketing and networking with potential referral sources (schools, the new group home, court systems, etc.)

5. Facilities development

6. Staff development

7. Development of a provider agreement with the State Medicaid office to provide treatment for Medicaid-eligible clients, including adolescents, pregnant women, and women with dependent children.

8. Pursue contracts with the State Division of Alcohol and Substance Abuse, Department of Corrections, Veterans Administration, and all other potential sources.

9. Bill private insurance companies for those clients that have private insurance. In order to do so, market to employers (the casinos, schools, college, Housing Authority, etc.)

All of this program development will need to be done with existing resources from I.H.S. and the Tribe. There is no funding available for capacity-building.

In principle, Tribes would agree with State policy that health care, including behavioral health programs and long-term care, are a Federal obligation, even an entitlement, to Indian people who have pre-paid these services through millions of acres of land. Practically speaking, however, the level of funding available does not meet the need and necessitates this pursuit of what we hope is not a mere mirage.

The Indian Health Care Improvement Act amendments offer hope that Congress may provide the overdue and much-needed financial resources for behavioral health programs in the new millennium. The psychiatric unit located at the Indian Health Service hospital in Rapid City has operated as a demonstration program under the Indian Health Care Improvement Act since its inception. They have already moved to a holistic, behavioral model. At the May 18, 2000, meeting

of the Aberdeen Area Tribal Chairmen's Health Board, Resolution No. 2000-024 was adopted to support *"the Rapid City Service Unit's request to become a Demonstration Project for Behavioral Health under Title VII of the proposed P.L. 94-437 Reauthorization Bill"*.

As a final point, I would like to cite yet one more study that is critical to understanding the great health disparities that exist between the Indian population and other Americans. This study is referred to as "Level of Need Funded" or "LNF". In a nutshell, the study calculates the cost of an equitable health benefits package for Indian people. It compares the amount which the Indian Health system is funded on a per capita basis with industry standards for mainstream health benefits. The comparisons are as follows:

COMPARISON OF PER CAPITA EXPENDITURES FOR INDIAN HEALTH WITH OTHER MARKERS AND ESTIMATED NEED

BENCHMARK	PER CAPITA AMOUNTS
National Expenditure for Health Care	$3,766
Medicaid Expenditure	$3,568
Indian Health Service Appropriations	$1,351
Level of Need Funded (LNF) Study Estimate of Need	$2,980

This data illustrates that a huge health-funding gap exists. The gap in health status disparities will not close unless the funding gap is reduced. A $1.2 billion budget increase is required to close the funding gap for 1.34 Indian users, nation-wide. This increase would address the "personal medical services" or medical model aspect of health care primarily - not public health "wrap-around", infrastructure or urban health services. This study has documented the fact that health service programs in Indian Country are funded at 45% of what's needed to provide core medical services.

Behavioral health - holistic treatment of body, mind and spirit - is a wrap-around service, is not measured by the LNF Study, and requires it's own study, as authorized in Section 701 of S. 2526.

The Memoranda of Agreement, as described in Section 702, should include behavioral health programs funded by other agencies within the Department of Health and Human Services, including the National Institute of Health, Centers for Disease Control, and National Institute of Alcohol Abuse and Addictions, in order to expedite and facilitate interagency cooperation, referrals, and individual case collaboration in the prevention and management of behavioral health risks and problems.

The sheer magnitude of disparities in life expectancy and infant mortality rates between first Americans and all other Americans justifies the need for the authorities and appropriation amounts set forth in this reauthorization bill. Accordingly, we seek your assistance and support in securing passage of this important Indian health legislation as soon as possible. It is a privilege to testify before you today.

COMPARISON OF HOUSE AND SENATE MARKUPS REGARDING HIS FACILITIES CONSTRUCTION

PROJECT	HOUSE MARKUP	SENATE MARKUP
Ft. Defiance, AZ Hospital	$40,115,000	$40,115,000
Winnebago, NE Hospital	12,286,000	12,286,000
Parker, AZ Health Center	8,210,00	8,328,000
Pinon, AZ Health Center	0	0
Red Mesa, AZ Health Center	0	0
Pawnee, OK Health Center	1,745,000	0
St. Paul, AK Health Center	0	0
Metlakatla, AK Health Center	0	0
Sisseton, SD Health Center	0	0
Zuni, NM Staff Quarters	0	0
PHX-NV Satellite Youth Treatment Regional Center	0	0
Joint Venture Projects	0	5,000,000
Dental Units	1,000,000	0
Small Ambulatory Grant Program	5,000,000	0
Hopi Staff Quarters – to assist with Tribe's debt (Not on the priority list)	*240,000*	*240,000*
Bethel, AK Staff Quarters (On priority list but not in President's 2001 budget request)	*0*	5,000,000
TOTAL	**$ 68,596,000**	**$70,969,000**

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TOTAL	**$ 68,596,000**	**$70,969,000**

STATEMENT OF

ANITA D. WHIPPLE, ROSEBUD SIOUX TRIBAL HEALTH DIRECTOR

S.2526 A BILL FOR THE

re authorization OF THE INDIAN HEALTH CARE IMPROVEMENT ACT,

FOR FIELD HEARING HELD BY SENATOR DORGAN, BISMARCK, ND,

AUGUST 1, 2000

Good morning Senator, Honorable Tribal Chairs, and guests, I want to thank you for the opportunity to present a statement on the proposed amendments to the Indian Health Care Improvement Act (P.L. 94-437). Mr. Jim Hagel accompanies me, Social Worker, at Sioux San IHS Service Unit, Rapid City, SD.

Due to cultural differences there is frequently misunderstanding regarding the definition or meaning of words such as entitlement. Entitlement in the non Indian world means *a contributory program whereas individuals have over a period, contributed to a fund and earned the benefits of a program,* such as with Medicare, and Social Security. To Indians of federally recognized tribes, Entitlement means *an outstanding unpaid bill for loss of economic status, land, culture, and punitive damages of historical grief and trust responsibility.* All concerned are familiar with Indian history as it relates to the cumulative poor health status of Native American Indians, especially within the Aberdeen Area.

Under the differences of definition the Direct Service Tribes are not asking more than their share nor are they asking for something free. Adequate increases in funding have not occurred sufficiently enough to make gains on the cumulative health problems created by a loss of lifestyles.

Tribes are requesting a fair, justified, stable payment for losses incurred as explained by these two charts. They must bring healthcare disparity and continual shortfalls compounded with a growing unmet need into equity with mainstream healthcare systems, b creating permanent appropriation legislation. The Aberdeen Area tribes request healthcare funding for Indian people become an entitlement program. We do not believe **eligibility or tribal resources** are involved in this issues as we continue to believe this is an outstanding bill owed for losses incurred. Due to the length of this bad debt the interest continues to grow in as seen with the current poor health status among the Northern Plains Tribes. Healthcare for the Nation's *first American's* must not be left in the President's discretionary budget, but must have permanent appropriations authorized by Congress as part of it's continuing treaty obligations, and in the interest of justice.

Emergency Medical Services is a major concern throughout the Nation, particularly as many injuries are alcohol /drug related. In recent years Congress and the President have focused on increasing law enforcement capabilities, and this is commendable, but for every violent crime needing law enforcement there is a victim (sometimes more than one) needing medical attention. Combined with the disasters occurring throughout the nation, the heart attack victims, and various other incidences needing emergency assistance, the need for a progressive, well grounded Emergency Medical Services system in healthcare delivery is essential. In 1966 the Highway Safety Act established the EMS program within the Department of Transportation. Seven (7) years later the Emergency Medical Services System Act provided federal guidelines and funding for development of regional EMS systems. This Act also established 15 costly components for EMS systems. Eight (8) years after they enacted the Emergency Medical Services Systems Act, the Omnibus Budget Reconciliation Act consolidated EMS funding into State Preventive Health

Services Block grants and eliminated funding under the EMSS Act of 1973. In 1990 The Trauma Care Systems and Development Act provides funding to States for Trauma systems planning, implementation, and evaluation. Congress does not

re authorize funds under the Trauma Care systems and Development Act in 1995. Currently EMS does not have authorizing legislation. This is an enormous problem, as no actual funding for Emergency Medical Services, especially within the Indian Health Service. They contract Emergency Medical Services, under the Indian Self-Determination and Education Act, (P.L. 93-638), through IHS to Tribes, who are having extreme difficulty staying in operation because twenty five years ago there was a basic need for emergency care that did not include all of the 15 components, additionally, funding has not increased since 1995. As alcohol and drug related injuries, domestic violence, technology, has increased, so has public demand for better trained EMS personnel, and more sophisticated communications, creating a need for a faster paced service. All U. S. citizens live in a state of denial, always thinking they will never need emergency medical services, we all assume a well trained, quality ambulance service will be there to help us immediately upon our need. We never give thought to what it takes to operate this service. We strongly urge Congress to evaluate how they fund Emergency Medical Services, particularly in Indian Country.

no current EMS authorization.

Unfortunately, Emergency Medical Services, crosses into all areas in the provision of Healthcare, Obstetrical care or transfer, pediatrics, critical disease conditions, accidents, and injuries, (either self inflicted or) caused by another with a behavior health problem. Behavior health comprises a variety of aspects related to the over all well being of a person. Most individuals who have an addictive nature can be dual and triple diagnosed. Alcoholic or drug-addicted individuals,

frequently have histories of sexual abuse and/or suicide attempts, and they also have physical health problems associated with their addictions. We must not fragment a person during the treatment process. The idea of treating the whole person is not a new concept, although attempted in various forms within the Indian Health Service. Combining mental health and alcohol/drug abuse is a good beginning, but we need more extensive thought in this area, as behavioral health includes almost any patient seen within any healthcare system. The diabetic patient having an amputation, has depression on various levels, the obstetrical patient, with a prolonged undiagnosed post partum depression, the emotionally abused child with behavioral problems in school, the poorly nourished elder, the non compliant tuberculosis patient, and the victim of alcohol related motor vehicle accidents with permanent damage that changes their lifestyle, are all in need of behavioral health treatment. Alcohol and drug addiction may be the root cause of many of these incidences, and we strongly agree with the current language in S.2526, there needs to be a facility in every area that would provide behavioral health for cases of dual and triple diagnosis, especially suicidal youth, and those who are harmful to others. The tribes within the Aberdeen Area, have long stated they wish to treat the whole person, and have gone on record supporting the Indian Health Service Unit in Rapid City, SD., becoming a demonstration project for behavioral health facility.
The Service Unit has beds available and is currently doing dual and triple diagnosis treatment.

We also offer the suggestion of a team approach when treatment of any patient is initiated. This would include (but not limited to), nutritional education, mental health evaluation, physical treatment and therapy if applicable, outreach and follow up for all patients, with each clinical visit. Community outreach and follow up is essential in overcoming the psychological barriers to

maximum good health, and appropriate funding in outreach is critical to the continued care needed. We realize this is initially expensive but eventually we would better serve a patient. The cost of complications and underlying destructive behavior would be addressed thus saving health care dollars, while reducing the poor health status of Indian people, and strengthening an ideal Public Health model of care.

This concludes my statement on S.2526, I would like to thank Senators Dorgan and Conrad for providing this opportunity to the Tribes within the Aberdeen Area, and I will attempt to answer any questions they may have. I could have written volumes, but I decided to submit supportive documentation with my statement. Thank you again.

POSITION PAPER
ENTITLEMENT

Webster's dictionary's definitions of entitle is as follows;

1. To give title to.

2. To provide a right, (entitlement is the noun form of the word.)

Congress gave title for health care to Indian people in 1954, via creating the Indian Health Service, and removing this responsibility from the Public Health Service Agency. They did not recognize entitlement inasmuch as they never enacted permanent funding legislation, nevertheless they gave title.

This Congressional action, gave Indian people the **right** to health services by establishing an agency specifically designated for the provision of health care to Indian people and Alaska Natives. From the onset an inadequate appropriation level, compounded the agency's difficulty in meeting the existing need. **By definition Indian Health Service already exists as an entitlement program.** Congress continues its initial mistake of creating an unmanageable ethnic disparity in health care, by failing to authorize permanent appropriation legislation at an acceptable level.

Congress has readily acknowledged its obligation and continues to recognize the Government to Government relationships it has with Indian Tribes, as based on treaties, existing law, and court decisions. Congressional representatives who do not understand this obligation to Indians exaggerate the complexity of establishing a Federal entitlement program for Indian people. The facts show the program is already in existence, but without adequate permanent funding.

They cannot question beneficiaries as Tribes have always reserved the right to decide their own membership. It is not within the Federal Government's authority to try to decide membership based on a blood quantum. The unfairness of being the only race of people who must constantly prove their ethnicity, for benefits accorded other minorities is degradation in its highest form.

Any form of tribal financial evaluation is unjustified, as the Federal Government forcefully assumed responsibility for the people whom they displaced from ancestral lands. The current financial status of a tribe is not an indicator of Federal obligation. Historically tribes are barely beginning to obtain resources to provide self-determined services. A financial evaluation of any thing in trust (land, mineral rights, water, timber, hunting /fishing rights etc.) violates treaty rights and erodes sovereignty. Additionally, it is unjust to financially evaluate anything with a lien against its' construction or operation, and any tribal business providing services to an impoverished people must not be included in any proposed financial evaluation of a tribe.

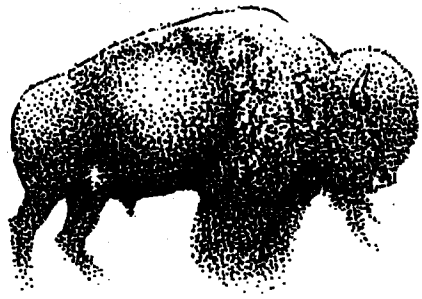
Funding for an Indian Health entitlement program could be actualized by a redistribution of federal health care dollars over a five year time span and combining this redistribution with existing Indian Health Service appropriations. Annually adding a population growth and inflation rate formula would ensure adequate funding was maintained in parity with other federal agencies providing health care. The Indian Health Service would need new appropriations for transition into entitlement.

Raising the health status of Indian people would benefit America, creating a healthier nation without pockets of poor health status and disparity. The Indian Health Service; properly funded could be a managed care model of excellence. A model easily adapted for third world countries, as most Indian Health Service Units have prioritized culturally specific public health concepts acceptable to indigenous people. This model has a market value in today's world.

An adequately funded entitlement program for Indian people will reduce the ever increasing need for contract health dollars, as Indian people will have better access to the provision of health care thus reducing the current morbidity and mortality rates.

THEN AND NOW
1492 - 2000

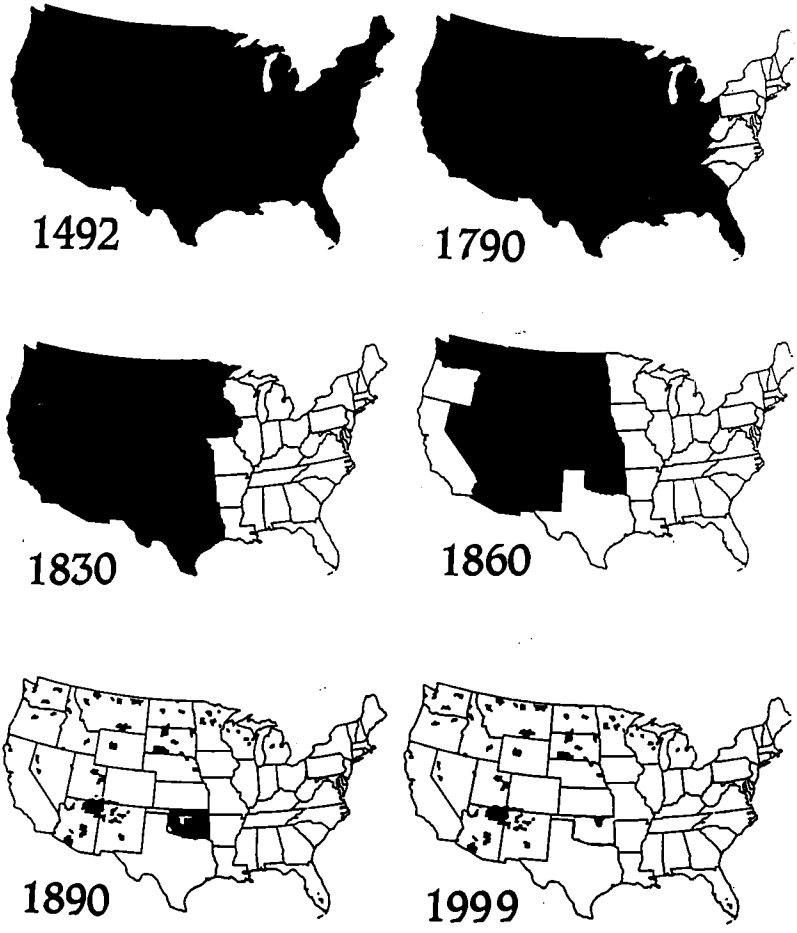
40 - 60 MILLION



250 - 300 THOUSAND
INCLUDING THE UNITED STATES & CANADA

* INTER-TRIBAL BISON COOPERATIVE - RAPID CITY, SD

THEN AND NOW



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POSITION PAPER
EMERGENCY MEDICAL SERVICES

Definition - *Emergency:* ***"an unexpected serious occurrence or situation urgently requiring immediate action."***

When calling 911 it is assumed qualified help is readily available for emergency assistance, ***but is it?***

By definition an emergency is an unexpected serious event in which the average United States citizen does not believe they will be involved, therefore, they do not think about who will be available to answer their call when they require assistance. As am example many places, especially in the western half of the United States do not have 911 systems available.

Emergency Medical Services (EMS) is a highly specialized field, requiring long hours of training, continuing education, certification and licensing, long working hours, low pay, hazardous working conditions, precise communications, and is all but forgotten until needed.

The Rosebud Sioux Tribe applauds the support Congress has given the President's initiative to increase law enforcement throughout the Nation, but focus only on the criminal element, neglects the victims who need immediate attention. Law enforcement is a good beginning, for every violent crime needing a police officer, usually they also need emergency medical personnel. All too frequently there is more than one victim, with a situation needing several teams of emergency medical personnel. Inclement weather, overwork, family problems, or personal illness, is not considered, citizens just want EMS personnel immediately on the scene for every heart attack, accidental injury, motor vehicle accident, bombing, house fire, diabetic coma, drunken brawl, rape, dog bite, domestic violence, stroke, explosion, stabbing, child bicycle/skateboard injury, pregnancy, respiratory problem, or hazardous spill that occurs. Additionally, U.S. residents do not consider what it takes to have an adequate EMS service in place. There must be well trained, certified, dedicated, personnel, adequate well-maintained vehicles, specialized equipment and supplies, up to date communications systems in good working order, clinical supervision, and compassion. All these components have costs attached.

The medical costs for the nation have skyrocketed in the last decade and EMS budgets have not kept pace with other areas of health care. EMS budgets have been flat since 1994-95 this is especially so within the Indian Health Service. Major increases covering medical inflation, cost of living allowances, increased technology in equipment, out dated/ obsolete communication systems, or the training for this technology, or the increased costs of vehicle maintenance, have not occurred.

EMS is the first link in the health care delivery system and throughout the Nation it is the weakest, due to lack of adequate local financial support. In many remote and rural areas it is the

primary access to health care. Most Emergency Medical Systems operate on a minimum budget, and many are strictly volunteer operated. EMS is not a priority and the operating budget is what any municipality, county, or local Indian Health Service (IHS) Unit decides.

Throughout Indian country, especially in the Aberdeen Area and specifically on the Rosebud reservation, The Indian health Services funds the ambulance service at 48-49% of need. Many Tribal services are considering recinding their contracts with IHS, as they are running out of funds long before the contract is due to end.

EMS has never been a program, function, or service of the Indian Health Service, but under the original P.L. 93-638 Indian Self Determination and Education Assistance Act of 1975, the Indian Health Service used the agency's authority to contract EMS to tribes. When they recognized the need for EMS and assumed this authority, Tribes accepted the idea IHS would also have the responsibility for maintaining this contracted access to emergency health care. We believe IHS contracted with Tribes in good faith to provide emergency medical services. Nevertheless, the agency as a whole and the entire Nation did not realize how important EMS would become and therefore neglected to see they adequately met the financial obligation to this service.

Questions need to be asked, "Where would we (as a country) be today without Emergency Medical Services? Does anyone know when they or their family will need an ambulance with trained personnel?" EMS saves lives, and reduces suffering! We must be aware of our unconscious reliance on EMS, always thinking we will not need to call for assistance. Never knowing when we will be involved in a motor vehicle accident, be the innocent bystander at a shooting, an unintentional victim of bombing, plane crash, or other terrorist act, has a heart attack, or simply fall on a patch of ice.

It is a service all expect to be available, anytime. EMS must become a priority by first making it an adequately funded presidential line item within the budget, secondly it must become a priority within the Department of Health and Human Services, and most importantly to all of Indian Country we must make the Indian Health Service recognize it assumed this responsibility when it used the agency's authority to contract it to tribes. They must fund EMS at 100% of need, and receiving increases annually for inflation and cost of living, personnel costs associated with increased training and expertise in skills, and population growth. Tribes recognize the fact, increased IHS funding is not a priority with the Office of Management and Budget (OMB), but considering the importance of EMS we suggest, Congress considers special appropriations for EMS, as it is an essential, but severely uncelebrated component of the social system. We further recommend special appropriations for Indian Tribes be distributed based on a formula containing health status, distance, and workload, factors in the budget formula.

As an example of need; the Rosebud Sioux Tribe has a contracted (through IHS) twenty-four hour ambulance service, with thirty-seven employees, including four paramedics, with the highest call volume in the State of South Dakota, an average of 425 calls per month (greater than the State's metropolitan areas of Sioux Falls, and Rapid City) with a minimum of three transfers per day to a medical center, average distance is 180-250 miles one way. The local Indian Health Service Unit does not have a fully functioning obstetrical or surgical unit, and for the last four

years we must transfer all high risk pregnancies, and surgeries to a private sector hospital, 180-260 miles away. Our trauma case load exceeds any in the State, but we pay our employees at an average rate of $8.15 per hour, without overtime. (Indian Health Service Drivers are paid $10.00 per hour) Indian EMT's, EMT-I's, and paramedics, have an additional burden of having to treat and transport family, friends and people they have known all their lives. This is emotionally and mentally devastating. Due to lack of adequate funds this program will be forced to cease its operation the first week in June. The local Indian Health Service Unit has stated they do not have any available funds to supplement this contract. Accident victims, and unborn children of complicated pregnancies will soon be dying on the Rosebud reservation if we cannot keep the ambulance service in operation.

We encourage every Tribe to support special appropriations for EMS and make continuous financing available for this essential service, by making it a presidential line item with appropriate funding, and last but not least we ask you to visualize our Nation without an Emergency Medical System in place.

ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD
RESOLUTION NO. 2000-08

PURPOSE: **TO REQUEST EMERGENCY MEDICAL SERVICES (EMS) BE MADE A LINE ITEM IN THE INDIAN HEALTH SERVICE BUDGET**

WHEREAS, The Aberdeen Area Tribal Chairmen's Health Board is composed of seventeen (17) Tribes and two (2) Health organizations in a four-state Area, North Dakota, South Dakota, Nebraska, and Iowa, and

WHEREAS, Federally recognized Indian Tribes have an absolute right to health care from the Federal Government, based on Treaty Rights, on Congressional Acts, on Federal Court Decisions, and on the Federal Government's trust responsibility to Indian Tribes, and

WHEREAS, the Aberdeen Area Tribal Chairmen's Health Board is primarily responsible for the health concerns and needs of the Tribes in the Aberdeen Area, and

WHEREAS, the Aberdeen Area EMS Program is consistently underfunded and the AATCHB feels it is not given adequate consideration in funding allocations, and Area tribes are experiencing many problems with their ambulance programs and other emergency medical services, as a result of that underfunding, now

THEREFORE BE IT RESOLVED, the AATCHB requests that Emergency Medical Services (EMS) be made a line item in the Indian Health Service Budget.

Certification

This is to certify that the foregoing Resolution was adopted by the AATCHB on February 3, 2000 during the 1st Quarterly Board Meeting at the Ramada Inn, Aberdeen, SD by a vote of 12 For 0 Opposed and 0 Not Voting.

Everette Enno

Everette Enno, Chairman, AATCHB & Trenton Indian Service Area

February 3, 2000
(Date)

ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD
RESOLUTION NO. 2000-05

PURPOSE: TO REQUEST SUPPLEMENTAL FUNDING FOR EMERGENCY MEDICAL SERVICES (EMS)

WHEREAS, The Aberdeen Area Tribal Chairmen's Health Board is composed of seventeen (17) Tribes and two (2) Health organizations in a four-state Area, North Dakota, South Dakota, Nebraska, and Iowa, and

WHEREAS, Federally recognized Indian Tribes have an absolute right to health care from the Federal Government, based on Treaty Rights, on Congressional Acts, on Federal Court Decisions, and on the Federal Government's trust responsibility to Indian Tribes, and

WHEREAS, the Aberdeen Area Tribal Chairmen's Health Board is primarily responsible for the health concerns and needs of the Tribes in the Aberdeen Area, and

WHEREAS, the Aberdeen Area EMS Program is severely underfunded and is experiencing many problems with their Ambulance Programs and other Emergency Medical Services, as a result of the lack of adequate funding in the present year's budget, now

THEREFORE BE IT RESOLVED, the AATCHB requests the Director, Indian Health Service provide Supplemental Funding to the current year Hospitals and Clinics Budget for EMS in the Aberdeen Area.

Certification

This is to certify that the foregoing Resolution was adopted by the AATCHB on February 3, 2000 during the 1st Quarterly Board Meeting at the Ramada Inn, Aberdeen, SD by a vote of 12 For 0 Opposed and 0 Not Voting.

Everette Enno

Everette Enno, Chairman, AATCHB & Trenton Indian Service Area

February 3, 2000
(Date)

EMSC FACT SHEET

INJURY INCIDENCE

This year alone, 14 million children under the age of 15 will be injured seriously enough to require medical attention.

Over 40% of all hospital emergency department visits by children under the age of 21 in the US are injury related.

One in four children visits an emergency room each year.

Each day in the US, over 24,000 children under the age of 15 seek emergency care.

One out of every 400 children requires admission to a pediatric intensive care unit every year, yet only 55% of those children in need of this care actually receive it.

Children account for approximately 10% of all emergency response transports.

For children, aged 5 to 14, injuries claim more than three times as many lives as the next leading cause of death.

DEATH AND DISABILITY

Injuries are the leading cause of death for children and young people between the ages of 1 and 1.

In 1994, more than 21,000 children and youth, aged 19 and younger, died from injury.

Each year, 16 million emergency room visits are made by those 1 to 19 years of age, of these, 600,000 require hospitalization and 30,000 have permanent disabilities.

INJURY-RELATED COSTS

The cost of injuries - in both human and economic resources - is approximately $413 billion annually for children ages 0 - 19.

The cost for a lifetime of custodial care for an individual child with severely disabling head injury is approximately $2.5 million.

EMSC FACTS AND FIGURES

While the majority of trained pre-hospital EMS personnel are volunteers, they cover only 20% of the population.

Many people do not have access to 9-1-1. Only 78% of the population and 25% of the geography is covered by the 9-1-1 emergency number.

Most states offer less than 15 hours of pediatric education in their paramedic training curriculum.

It costs between $80,000 to purchase a fully equipped ambulance.

*American Academy of Pediatrics

*Children's Safety Network Economics & Resource Center

*Maternal & Child Health Bureau Fact Sheet, 1994

*Adolescent Emergency Visit Data Book

*National Center for Health Statistics

*National Center for Injury Prevention & Control

*US Surgeon General

*National Head Injury Foundation

*International Association of Fire Fighters

*EMS Agenda for the Future

*National Association of EMS Educators

*Government Services, 1997

ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD
RESOLUTION NO. 2000-034

PURPOSE: **TO SUPPORT THE RAPID CITY SERVICE UNIT REQUEST TO BECOME A BEHAVIORAL DEMONSTRATION PROJECT.**

WHEREAS, The Aberdeen Area Tribal Chairmen's Health Board is composed of seventeen (17) Tribes and one (1) Health organization in a four-State Area; North Dakota, South Dakota, Nebraska, and Iowa, and

WHEREAS, Federally recognized Tribes have an absolute right to health care from the Federal Government, based on treaty rights, on Congressional Acts, on Federal Court decisions, and on the Federal Government's trust responsibility to Indian Tribes, and

WHEREAS, The AATCHB is primarily responsible for the health concerns and needs of the Tribes in the Aberdeen Area, and

WHEREAS, currently, under Title II, section 2 of P.L. 94-437, the Rapid City Service Unit is an in-patient Mental Health Demonstration Project, and

WHEREAS, under the proposed P.L. 94-437 Reauthorization Bill, behavioral health will be under Title VII, as a demonstration project and the scope of work will change, and

WHEREAS, the Rapid City Service Unit is in position to meet the proposed change, and has requested approval of the Aberdeen Area Tribal Chairmen's Health Board in seeking to be one of the demonstration projects under Title VII of the proposed 94-437 reauthorization, and

WHEREAS, The Tribal Health Directors have reviewed this request and feel it is beneficial for the Aberdeen Area, and agreed to support the request to become a Behavior Health Demonstration Project, with the condition only "demonstration-specific set aside dollars" would be used., now

THEREFORE BE IT RESOLVED, The Aberdeen Area Tribal Chairmen's Health Board approves and supports the Rapid City Service Unit's request to become a Demonstration Project for Behavioral Health, under Title VII of the proposed P.L. 94-437 Reauthorization Bill..

CERTIFICATION

This is to certify that the foregoing Resolution was adopted by the AATCHB at its Quarterly Board Meeting at Hankinson, ND on May 18, 2000 by a vote of 10 FOR, 0 Opposed and 0 Not Voting. CARRIED

Everette Emmo, Chairman, AATCHB

5-18-00
Date

P.O. Box 590
Eagle Butte, South Dakota 57625
(605) 964-4155
Fax (605) 964-4151

July 21, 2000

The Honorable Byron Dorgan
United States Senate
713 Hart Senate Office Building
Washington DC 20510

Dear Senator Dorgan:

As Chairman of the Cheyenne River Sioux Tribal Nation, I have long been concerned with regard to the inadequate health care provided to the people of the Cheyenne River Reservation.

Our people continue to suffer from disease rates that are far in excess of those of the Nation as a whole and even exceed the rates of other areas of the Indian Health Service.
Recently, this situation appears to have worsened, especially as it relates to in-patient care capabilities.

We strongly urge you to keep this in mind as you begin the task of deciding the future of our Tribal Nation's health care through the reauthorization of this important legislation.

We have attempted to address major issues that will have the greatest impact on our Tribal Nation's health status. Realize these comments are provided in all sense of fairness and sincerity and we trust you will consider them in that same regard.

We as a Tribal Nation stand ready to assist you any way we can to alleviate premature death and suffering amongst our people resulting from a failure by Congress to adequately fund Indian health programs.

If you should need additional information, please contact Mr. Jayme Longbrake, Cheyenne River Sioux Tribe Health Administrator at Telephone (605) 964-6190 or Fax (605) 964-1062.

Sincerely,

Gregg J. Bourland, Chairman
Cheyenne River Sioux Tribe

Attachment (1)

The blue represents the thunder clouds above the world where live the thunder birds who control the four winds. The rainbow is for the Cheyenne River Sioux people who are keepers of the Most Sacred Calf Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for

CHEYENNE RIVER TRIBAL NATION POSITION PAPER

ON THE REAUTHORIZATION AND REVISIONS

TO THE INDIAN HEALTH CARE IMPROVEMENT ACT

The reauthorization of this legislation is essential to the efforts of all Tribal Nations to continue the process of improving the health care of our Tribal members.

To briefly summarize, we strongly support the Government-to-Government Consultation process and the proposed amendments. We strongly urge Congress to increase appropriations to a level consistent with that provided to the nation as a whole and would hope Congress will see fit to fund those sections that have been authorized but never funded.

In these times of prosperity, it is heartbreaking to watch our people continue to suffer from diseases whose rates can only be compared to those of some of the more disease ravaged Third World Countries. In this period of extended budget surpluses, we urge Congress to utilize a portion of this surplus to raise the level of funding for Indian Health programs which in this area are funded at less than 50% of the known unmet needs. This results in suffering and early death for many tribal members. We feel the Indian Health Service goal of "Raising the Health Status of the Indian people to the highest level" is innocuous and should be more specific i.e. "at least to the same level as the health status enjoyed by the rest of the nation".

The IHCIA along with the Snyder Act is the legislation at the core of the Federal Government's responsibility for meeting the health needs of AI/AN. Since this legislation contains a wide ranging list of provisions, many of which have significant budget and management implications across Indian Country, a thorough review and careful consideration are necessary to ensure continued improvement of Indian health care. Specifically we will address each title individually as it relates to issues that affect the daily lives of our Tribal members and impacts upon their health and welfare.

TITLE I - INDIAN HEALTH HUMAN RESOURCES AND DEVELOPMENT

We certainly support the two-fold purpose of this title:

1.) To increase the number of Indian students entering the health professions; and,

2.) To assure an adequate supply of health professionals to the Indian Health Service and to Urban and Tribal Health delivery systems.

Of particular interest is new language added in section 116 to require that "appropriate employees" undergo instruction in the culture and history of the Tribe whose members they provide services to, which would be provided by tribal colleges, if possible. The cultural sensitivity training may be more appropriately provided by Tribal Councils. This should greatly reduce staff turn over amongst non-member medical staff.

We would support language to require Title I recipients to fulfill their scholarship and job placement requirements in the areas from which they receive their scholarship assistance.

We also strongly support language that would designate all programs operated by Tribes as health profession shortage areas. Tribal Health profession staffing needs must be given consideration on an equal basis with programs operated by the Indian Health Service. There should be no change for those students already in the "pipeline" regarding their priority status.

TITLE II - HEALTH SERVICES:

We fully support the goals of Section 201, which would reinstitute the Indian Health Care Improvement Fund. Section 201, "(a)" (5) Augmenting the Ability of the Services to meet the following health service responsibilities with respect to those Indian Tribes with the worst level of health status and resource deficiencies in the following categories:

(A) Clinical Care

(B) Preventive Health

(C) Dental Care

(D) Mental Health

(E) Emergency Medical Services

(F) Treatment and Control of/and rehabilitative care related to alcohol and drug abuse.

This must surely have been written specifically for the "Aberdeen Area" in general and each of the Tribal Nations in this area in particular. Unfortunately, the Aberdeen Area Indian Health Service and Tribal Health patients suffer from the worst health status and have the greatest resource deficiencies in the nation. It is estimated this area is funded at 47% of the amount the Indian Health Service calculates as the resources needed to fund

100% of the Area's known health needs. It seems so unconscionable that as we enter the twenty- first century in a nation with unprecedented prosperity that Native Americans continue to be afflicted by disease at rates much greater than other races; they continue to suffer more and longer; and many die decades earlier than they should because they lack access to health care that is adequate.

Year after year studies have revealed that prevelance of Diabetes amongst Indian people has increased at an alarming rate. Type II (Onset) Diabetes is epidemic amongst younger tribal members. Recently a thirteen (13) year old female member was diagnosed with Type II Diabetes. On average, three (3) additional tribal members are diagnosed per week with Type II Diabetes. It is believed that many, many more are in a state of denial. Complications of this dreaded disease continue to devastate many members of our Tribal Nations.

Historically, Diabetes was unheard of in Indian Country, before we were subjected to an abrupt change in our lifestyle. We were the healthiest people on Earth. We were highly mobile, subsisting on a diet rich in protein and low in carbohydrates.

Studies have indicated our Indian bodies react differently to carbohydrates, fats and sugars. Therefore, research done on the effects of Diabetes on Indian people must be conducted on Indian people to have meaningful results.

We strongly support the goals of Section 204 that would make model Diabetes programs recurring through the Year 2012. We urge Congress and the Administration to be generous with resources to implement this section in a meaningful way to prevent and control Diabetes.

The Cheyenne River Sioux Tribal Nation strongly supports the revision to Section 204 which includes Authority for funding to establish, equip and staff kidney Dialysis programs to treat the burgeoning number of diabetics suffering from renal failure.

This area continues to receive less than its equitable share of Indian Health Service funds because of the capitation based funding formula adopted by Indian Health Service Headquarters. A capitation-based distribution formula penalizes us because of the high percapita usage of health services in the Aberdeen Area. To correct this inequity, we strongly encourage language that would mandate the usage of weighted health status; particularly, years of productive life lost (YPLL) by Indian Health Service. We strongly recommend that area offices consult with local Tribal Nations regarding fund distribution rather than relying upon the central office to make the distribution on their behalf.

We strongly support the expanded services in Section 213 to include hospice care, assisted living, long-term health care and traditional health care.

The Cheyenne River Sioux Tribal Nation operates the only EMS services within a 50 mile radius. The program is seriously under funded as the primary link to our outlying communities for patients with emergency health care needs. This constitutes a serious breach in our health delivery system. Therefore, we urge Congress to appropriate sufficient EMS funding as a recurring line item in the budget.

We support all other sections of Title II and urge Congress to fund the appropriate sections in a meaningful way.

The Cheyenne River Sioux Tribe opposes the current Indian Health Service Contract Health Care Priority System as being neither economically sound nor conducive to the provision of quality health care. The Cheyenne River Sioux Tribal Nation urges Congress to establish a committee which includes consumers to research the devastating affect this priority system is having on the ability of our patients to access health care at the most appropriate time to insure the most desirable medical outcome in the most cost effective way.

TITLE III - FACILITIES:

We appreciate Congress' commitment to continue to expend funds for the planning, design, construction and renovation of health facilities on behalf of Tribal Nations.

The Cheyenne River Sioux Tribal Nation, along with others in this area, is in dire need of expanded health care facilities with sufficient staff to meet the current demands for outpatient and inpatient services. Limited health care capabilities of our local facility together with limited Contract Health Care dollars leaves many patients with no access to health care for extended periods of time. This phenomenon results in needless patient suffering and premature death in many cases.

We support the various sections of Title III including the requirement for Tribal Consultation in all facility issues and the language encouraging Tribal Nations to become creative and innovative in their approach to facility construction. To further enhance this

section, we urge Congress to support the design and construction of inpatient facilities under the Joint Venture Health Facilities Demonstration program.

With regard to the establishment of a facility priority system by the Secretary, we recommend the establishment of a base-funding amount to ensure the completion of those facilities that have gone through the process of review and approval. It is our position that because many Tribal Governments have spent years getting their project on the list, it would be unfair to those Tribes to amend the priority system at this time.
It is also our position that greater emphasis should be given to unmet health needs and health status and more weight placed on remoteness in establishing a health care facility priority list.

We also urge Congress to consider the total need of all Tribal Nations when determining facility needs even though those with critical needs may exceed ten in any one of the stated categories. Congress should adopt this policy initially until the playing field is leveled before placing a limit on the number of facilities it will consider for funding in each category in each reporting period.

TITLE IV - ACCESS TO HEALTH SERVICES:

We support the provisions in this title that attempt to eliminate barriers which prevent Indian Health Service, Tribal Nations and Urban organizations from fully accessing reimbursement from other Federal Programs including Medicaid, Medicare and Children's Health Insurance Program (CHIP).

Severe and longstanding lack of adequate appropriations to Indian Health Service require that alternative funding be accessed to the maximum extent possible.

Recently the South Dakota State Legislature extended a moratorium on licensure of long-term health care (nursing home) facilities. Because a state license is required as a preliminary condition of eligibility to receive reimbursement for services provided to eligible beneficiaries under Medicare/Medicaid, the Tribal Nations in this State have been effectively blocked from participating under Title XVIII and Title XIX of the Social Security Act.

Many of our Elders are being denied long-term health care and other elderly health care because this care is not available on the Reservation.
Most Indian elders are opposed to leaving their families to travel hundreds of miles to surrounding non-Indian communities for long-term health care but they must because this is not available locally.

Therefore, the Cheyenne River Sioux Tribal Nation strongly supports direct reimbursement of services provided to eligible beneficiaries of Medicare and Medicaid for long term health care, assisted living health care and other elderly health care. Direct reimbursement from HFCA to Indian Health Service and Tribes for long term health care, assisted living health care and other elderly health care programs under terms that waive all cost sharing for eligible beneficiaries served by Indian Health Service or Tribally managed long term health care facilities under Medicare, Medicaid or CHIP is critical to

ensure that Indian health programs have fair access to all Federal funding sources and the opportunity to modernize their programs to address the needs of and to fulfill the responsibility of the United States to Indian people.

Also, the Cheyenne River Sioux Tribal Nations support language that would permit Tribal Health programs to bill for and receive reimbursement for services provided to eligible beneficiaries under Medicare and Medicaid even when the facility in which these services are provided is owned by the Federal Government.

TITLE V - HEALTH SERVICES FOR URBAN INDIANS:

We appreciate and strongly support Congress' efforts to make quality health care available to Tribal members, who for whatever reason, choose to live in Urban areas. We favor language proposed to permit urban programs to receive lump sum payments for Indian Health Service contracts or grants under the title and to use carry-forward funding from one year to the next.

TITLE VI - ORGANIZATIONAL IMPROVEMENTS:

We urge Congress to act quickly to elevate the Director of Indian Health Service to an Assistant Secretary for Indian Health. With respect to the appointment of an Assistant Secretary for Indian Health appointed by the President with the advice and consent of the Senate, we support language that would require consultation with Tribal Governments prior to and during the appointment process with Tribal Governments being given the

opportunity to submit the names of qualified individuals, one of which will be selected by the President and the Senate.

TITLE VII - BEHAVIORAL HEALTH PROGRAMS

As we enter a new millenium it is heart-rending to be continually reminded of the "Grim Statistics in Indian Country"; e.g. Native American disease rates compared to all other races:

1. Alcoholism	**627% Greater**	**4. Accidents**	**204% Greater**
2. Tuberculosis	**533% Greater**	**5. Suicide**	**72% Greater**
3. Diabetes Mellitus	**249% Greater**	**6. Homicide**	**63% Greater**

While these overall statistics are alarming, more alarming still is the fact that the Aberdeen Area patients' health status is much worse than the average for the Indian Health Service as a whole due to the inequity inherent in the Indian Health Service distribution methodology which is primarily per capita driven.

These grim statistics continue to reflect the effect of cultural oppression, loss of traditions, a long history of forced internment on Reservations and a drastic change in lifestyle for our people; however, we feel it is time for us to join hands and resolve to improve upon the health status of the members of all Tribal Nations.

The aim of this title appears to attempt to integrate substance abuse, mental health and social services into wholistic behavioral health programs. The Cheyenne River Sioux Tribal Nation has consistently taken the leadership role in addressing the myriad of needs

associated with behavioral health problems; therefore, we strongly support integrating programs which are nurturing, fulfilling, accountable and responsible in offering significant opportunities for all Tribal Nations to enjoy wellness through a balance of modern medicine and traditional beliefs and treatments.

We urge Congress to provide adequate funding to begin to make significant measurable improvements in health status in the Aberdeen Area Indian health care.

TITLE VIII - MISCELLANEOUS

The Cheyenne River Sioux Tribal Nation strongly supports the establishment of a commission to study the questions which need to be resolved in defining entitlement and to making health care an entitlement as opposed to discretionary funding. As Treaty Tribes, we believe that health care is an entitlement by virtue of these treaty rights and as ratified by passage of the Snyder Act by Congress in 1921.

Of the twelve Indian Health Service areas, the Aberdeen Area IHS, comprised of North Dakota, South Dakota, Nebraska and Iowa, suffers from higher disease rates, and is under resourced to a greater extent than other areas. These factors combine to place an added burden on an already strained health delivery system.

Health care in this area is so inadequate that the life expectancy amongst tribal member is 6 years less than the IHS average and 12 years less than the national average. Diabetes is occurring at epidemic rates, even among juveniles. Amputations from diabetes complications are occurring at an alarming rate and Tuberculosis has once again become a threat to the lives of our members, largely because of lack of an adequate health facility

that is sufficiently staffed to provide daily patient care. This all points out the need for additional resources to improve health care in the Aberdeen Area.

Thank you for allowing the Cheyenne River Sioux Tribal Nation to express its opinion with regard to this important piece of legislation, its reauthorization and various amendments thereto. We urge Congress, as you consider this legislation, to consider the consequences to Indian people of continued under resourcing of our health programs.

RESOLUTION NO. 159-00-CR

WHEREAS, the Cheyenne River Sioux Tribe of South Dakota is an unincorporated Tribe of Indians, having accepted the provisions of the Act of June 18, 1934 (48 Stat. 984); and

WHEREAS, the Tribe, in order to establish its tribal organization; to conserve its tribal property; to develop its common resources; and to promote the general welfare of its people, has ordained and established a Constitution and By-Laws; and

WHEREAS, Congress is currently considering the Indian Health Care Improvement Act Reauthorization of 2000; and

WHEREAS, the Indian Health Care Improvement Act along with the Snyder Act is the core of the Federal Government's responsibility for meeting the health needs of all eligible Native Americans; and

WHEREAS, the Aberdeen Area Indian Health Service and tribally managed health programs are seriously under-resourced, causing our people to be afflicted by disease at rates much greater than other races and to suffer more and die much earlier than they should because they lack adequate health care; and

WHEREAS, it is important that we influence the Amendments to this Act to the greatest extent possible, to improve on health care throughout Indian Country; now

THEFORE BE IT RESOLVED, that the Cheyenne River Sioux Tribe does hereby authorize the submittal of a document entitled the "CHEYENNE RIVER TRIBAL NATION POSITION PAPER ON THE REAUTHORIZATION AND REVISIONS TO THE INDIAN HEALTH CARE IMPROVEMENT ACT," as our official comments relative to this proposed legislation.

RESOLUTION NO. 159-00-CR
Page Two

CERTIFICATION

I, the undersigned, as Secretary of the Cheyenne River Sioux Tribe, certify that the Tribal Council is composed of fifteen (15) members of whom 11, constituting a quorum, were present at a meeting duly and regularly called, noticed, convened and held this 7th day of July, 2000, Regular Session; and that the foregoing resolution was duly adopted at such meeting by an affirmative vote of 11 for, 0 against, 0 not voting and 4 absent.

Colette LeBeau Iron Hawk, Secretary
Cheyenne River Sioux Tribe

Statement of
Bob Hall, Executive Director
Urban Indian Health Center
Pierre, South Dakota
On S. 2526
the Indian Health Care Improvement Act
Reauthorization of 2000
August 4, 2000

Introduction. Honorable Chairman and Committee Members, my name is Bob Hall, Executive Director of the Urban Indian Health Center in Pierre, South Dakota and a board member of the National Council of Urban Indian Health. Thank you for this opportunity to testify with regard to S. 2526.

For nearly all of us in this room, there is no material possession more important to us than our health. Most Americans take for granted that they will have access to the world's leading health care services and health care technologies. However, this is not the case for many American Indians, as statistic after statistic so painfully reveals.

Support for the National Council of Urban Indian Health. I strongly support the testimony that has already been presented to the Committee by the National Council of Urban Indian Health on March 8, 2000 and July 26, 2000. In particular, I would like to add my support to NCUIH's testimony regarding the importance of including "Urban Indians" in the Congressional policy statement, and to restoring state-recognized Indians to the definition of "Urban Indian." I would like to make a few additional general remarks about Indian health care, and then focus on Title VII and VIII, the principal subjects of today's hearing.

The Purpose of the Indian Health Care Improvement Act. The original purpose of the Indian Health Care Improvement Act, as set forth in a contemporaneous House report in 1976, was "to raise the status of health care for American Indians and Alaska Natives, *over a seven-year period*, to a level equal to that enjoyed by other American citizens." House Report 94-1026, Part I, p.13.

It has been twenty-four years since that commitment was made, and seventeen years since the deadline for achieving it has passed. And yet Indians, as a group, continue to occupy the lowest rung on the health care ladder, with the poorest access to America's vaunted health care system.

Frankly, we are nowhere near the goal of achieving equal health care for American Indians. I challenge this Committee to think in terms of that goal, set twenty-four years ago, as it assesses what will work for Indian country and, just as importantly, as it implements its trust responsibility to the American Indian people.

Title VII. As a general matter, I am pleased to see that urban Indians are included in a number of the behavioral health programs and initiatives which would be established under Title VII of S.2526. The following provisions are of particular note: Under S. 2526, the IHS would have to set aside for urban Indian organizations (1) 20 percent of any amounts appropriated to develop and implement behavioral health treatment programs for Indian women; and (2) 10 percent of any amounts appropriated to establish and operate fetal alcohol disorders programs. The special health needs of Indian women, as well as the serious problem of fetal alcohol disorder, are as common among the urban Indian population as the reservation population. These amendments will give the urban Indian organizations critically needed funding to combat these problems.

Title VIII. Title VIII of the Act contains two provisions that address consultation and rulemaking issues with respect to all of the Titles in the Act:

- **Regulations.** The Secretary would be required to initiate negotiated rulemaking procedures to promulgate regulations necessary to carry out the amendments. A majority of members of the negotiated rulemaking committee would be representatives of tribes, tribal organizations, and urban Indian organizations from each service area.

- **Plan of Implementation.** The Secretary would be required to prepare, in consultation with tribes, tribal organizations, and urban Indian organizations,

and to submit to Congress a plan for implementation of any amendments adopted within 240 days of enactment.

These provisions are important as they assure that the entire Indian client population, including urban Indians, is truly consulted when it comes to these critical health care regulations.

Title VIII: National Bipartisan Indian Health Care Entitlement Commission. Title VIII also provides for the establishment of a National Bipartisan Indian Health Care Entitlement Commission. The purpose of the Commission would be to make recommendations to the Congress to implement a policy that would establish a health care system for Indians based on delivery of health services as an entitlement. The Commission would be composed of 25 members, with at least one a nominee of an IHS-funded urban Indian health program. Again, we support this effort and the inclusion of all groups, including urban Indians, in the planning process.

Conclusion. I would like to thank the Committee for considering this testimony. For too long, words have not been matched by deeds when it has come to Indian health care. It is my hope that this legislation will begin a new, and better chapter, in the history of the United States and its Native peoples.

MANDAN, HIDATSA, & ARIKARA NATION

Three Affiliated Tribes • Fort Berthold Indian Reservation

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United States Senate
Committee on Indian Affairs
Hearing on S. 2526
Revising and Reauthorizing Indian Health Care Improvement Act
August 4, 2000

Prepared Statement

Tex G. Hall
Chairman, Three Affiliated Tribes

Senator Dorgan, Mr. Chairman, members of the Committee:

Previously I have provided written testimony to the Senate Committee on Indian Affairs on behalf of the Three Affiliated Tribes, recommending amendments to the legislation that will that provide a preference for IHS designated areas whose health status, as measured by the most recent statistics available, and as particularly measured by life expectancy, is significantly less than the average for all IHS areas. This change is critical to begin if the IHS Aberdeen Area will ever be able to provide an adequate level of health care to Tribal members. I invite the Committee on Indian Affairs to carefully consider our request for the suggested amendments.

Today I would like to focus on a few specific health care problems of the Three Affiliated Tribes. This testimony will also provide further comment on the two titles to the Indian Health Care Improvement Act that are under discussion, as well as further discussion concerning the availability of prescription drugs for our members.

1. Facilities – a rural hospital – 24 hour health care.

Prior to the construction of the Garrison Dam, in the early 1950's, which flooded our ancestral homelands, we had a rural hospital in Elbowwoods, our Tribal headquarters. We were promised, as some of the people at this hearing will tell the Committee, that all of our infrastructure, including the hospital, would be replaced.

We have no new hospital. We do not even have 24 hour, 7 day a week health care. Instead, we have a clinic which provides doctors only 8 hours per day. During the past nine-months, emergency care services increased 160% at the nearest health facility on the Reservation that does provide such coverage; IHS could not provide adequate services. This is unacceptable and must be changed.

The facilities construction Title of the revised Indian Health Care Improvement Act (IHCIA), Title IV, puts Tribes again on a waiting list for adequate facilities. New health care facility construction for the Tribes that need such facilities, including ours, must be a priority for this and future Congresses.

2. Emergency Services.

In conjunction with the need for 24 hour, 7 day a week health care services, which should ideally be provided by a rural hospital, we need to have an adequate emergency medical care that IHS currently does not provide. The following are some of the problems:

-- Lack of local emergency care. Right now, if a person calls up the 800 number for after hours care, the doctor on call refers the individual to a Minot or Bismarck, hospital, hospitals which are anywhere from 40 to 170 miles from the person calling. The individual may be in need of immediate assistance, but either must drive to Minot or wait for an ambulance, if one is available. The reason for this referral is that after-hours, the local clinic, only being open 8 hours per day, is not staffed for emergency services that might be needed, such as radiology, nor is the pharmacy staffed after hours, so the doctors on call do not want to try to provide assistance without adequate services being available to them.

-- Lack of ambulance service. Most of the counties in which our reservation is located have ambulance services. However, the Mountrail County Ambulance service, which depends almost entirely on volunteers, but which serves a large number of our members in the New Town area, is understaffed and does not have the resources to provide continuous quality service. On top of their own problems, because the Four Bears communities, which technically are in McKenzie County and should be served by the McKenzie County Ambulance Service (45 miles away), are so close to New Town (5 miles away), the McLean County Ambulance Service often is called to serve the Four Bears Communities. McLean receives little, if any, funds from McKenzie County for this service, and the compensation from the IHS for the service is slow in arriving or does not come at all. The IHS needs its own emergency vehicles for transport to local hospitals or clinics. This illustrates the great need for additional appropriations for then Catastrophic Health Emergency Fund (CHEF), the authorization for which is provided in Section 202 of the revised IHCIA.

3. Improvements to community-based health care delivery system.

-- Improvements needed at each of our community clinics. At present, none of our community clinics can operate full time. People must wait to see a doctor on specific days of the week. Facilities in Parshall, Mandaree and White Shield all need upgrading, with better equipment and more staff. These facilities must be upgraded to meet the community needs.

-- Home health care services needed. As provided in Sections 201 and 213 of the revised IHCIA, home health care delivery systems are authorized by the Act. Such services are vital to a rural area like ours, where people often live in isolation and are subject to the vagaries of severe weather, preventing them from venturing out to the rural clinic setting. We need to have a Community Health Representative system that meets the needs for such care and the resources to make it work.

-- Rural transport services. I have already mentioned the need for a better ambulance service for all of our reservation residents. But not only emergency transportation services are needed. Many of our elderly citizens do not have adequate transportation. A rural transportation service specific to the Fort Berthold Reservation is desperately needed for our elderly citizens so that they can be transported to the rural clinics that serve our members, and when those clinics cannot provide the necessary services, to the nearest hospitals for emergency and other care.

All of the above needs are authorized in one way or another by the revised Indian Health Care Improvement Act of S. 2526, but Congress must appropriate sufficient funds for these needs. We urge the Committee to enact S. 2526 and then to work diligently to seek the appropriations necessary to make the Act work.

4. Prescription Drugs.

Only 26% of Three Affiliated Tribes members have access to alternate health care resources, such as private insurance, Medicare or Medicaid. These same people do not have adequate resources to take advantage of the newest prescription drugs that are available for many health problems.

Our IHS facility has a limited "formulary" or list of approved prescription drugs, because of limited resources. In fact, the formulary may often not be up to date, as the latest concern over an older diabetes drug known to have some well-documented adverse side effects indicates. We must have up-to-date formularies which take into account the best drugs the fast changing research conducted by pharmaceutical companies can produce.

5. Contract Health Care Services Delivery Areas.

One of the sections of the revised IHCIA provides that all of the state of Arizona is a Contract Health Care Service Delivery Area. (CHSDA). Yet, neither all of North or South Dakota are considered CHSDAs. That must change. When a Three Affiliated Tribes member is in Bismarck, and they need health care provided by a hospital or clinic in Bismarck, they are taking their financial future in their hands to seek such services, because of the strong possibility that the IHS Service Unit in New Town will not approve the health care bill that is generated when such services are provided.

That is unacceptable. We must have adequate contract health care dollars for the entire Aberdeen Area, so that our Tribal members do not need to fear that their life savings will be threatened when they seek medical care in a community that is not within the CHSDA. It is totally unacceptable for one state, Arizona, to get designation as a CHSDA and for North and South Dakota to be left out.

In addition, in our CHSDAs, we are in a Priority I status, and have been for many years, which means that our ailments must be life- or limb- threatening before contract health care dollars will

pay for the services sought by our members. Again, in an age of budget surpluses in the trillions of dollars, this is totally unacceptable to our members.

Title VII -- Substance Abuse programs.

Substance abuse, particularly alcohol abuse, is at epidemic levels on the Fort Berthold Reservation, as is indicated by the mortality rate from alcohol abuse in the most recently published IHS statistics and our own Gallup statistics from the State of North Dakota. We need two kinds of facilities:

1) 24 hour inpatient care for those who need special care for acute substance abuse problems.

2) A nearby inpatient substance abuse facility staffed with health care professionals. Right now, there are no local inpatient facilities available for our members. While inpatient care for substance abuse has declined in recent years, in part due to its cost, we know that for chronic abusers inpatient care provides the only mechanism with a significant chance of success. In addition, we need to straighten out the problems associated with use of our State hospital, not just in North Dakota for Tribal members, but also in South Dakota.

Again, adequate funding of the various components of Title VII of the revised IHCIA will help tremendously in this regard.

Title VIII. General Provisions.

Under general provisions are two key elements of the revised Indian Health Care Improvement Act.

-- 1. Negotiated Rulemaking. A central feature of the revised IHCIA is the idea of negotiated rulemaking, whereby Tribal leaders, health care providers and IHS officials would determine the formulas for distribution of funds available under the IHCIA. While we favor this direct negotiated approach to rulemaking as opposed to regulations made by faceless bureaucrats in Washington, D.C., we also must urge that the system be structured so as to give greater voice to those IHS delivery areas with the greatest need.

Right now, there is a pitifully small fund which is supposed to assist with regional differences in health status and health care delivery systems. That must change, and a preference must be given, as outlined in my previous testimony delivered in March, 2000, for those IHS areas where health status is significantly lower than other IHS delivery areas. Without such preference, our members will continue to die before they should, and we will continue to lose our members, our loved ones and our relatives at a far too frequent rate to diseases that can be prevented with an adequate health care system.

-- **2. Entitlement.** Title VIII also establishes a Native American Health Care Entitlement Study Commission. Over an 18 month period, this Commission would study the feasibility of establishing health care as an entitlement for Native Americans in the United States.

We believe that a combination of our Treaties, the long standing trust obligation of the U.S. towards its indigenous peoples, and more than 125 years of statutes providing for health care for Native Americans provides more than adequate authority for health care for Native Americans to be treated as an entitlement. The Commission established has broad powers to make recommendations to Congress to establish health care for Native Americans as an entitlement that will allow care to be provided to Native Peoples wherever the are located within the United States. We urge the Committee to leave this section intact and to properly fund the important work of the Commission as soon as possible.

Summary

Our health care systems on the Fort Berthold Reservation are in great need of repair, redesign and adequate resources so that our health care professionals can do their jobs to provide health care up to the standards stated in the Indian Health Care Improvement Act as revised by S. 2526. We need, and the rest of Indian country needs the following:

1. 24 hour clinic or hospital facilities that will provide comprehensive care on a 24 hours, 7 day a week basis.

2. Adequate medical transportation systems.

3. A preference for funding in the Aberdeen Area.

4. An entitlement system that works well for all Tribal members in the United States.

5. A formulary that represents the best that research can offer.

6. A health care system that provides available, timely, fundamental health services for all of our Tribal members.

Thank you for the opportunity to present this testimony to you today. I look forward to working with you further to secure the passage of S. 2526.

Testimony

Native American Children & Family Services Training Institute

Submitted to the Senate Committee On Indian Affairs

REGARDING S.2526

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

August 1, 2000

Susan Paulson
Director

The Native American Children and Family Services Training Institute hereby submits the following written testimony in response to S. 2526 the reauthorization of the Indian Health Care Improvement Act based on the experiences of said Institute with the Sacred Child Project. The United Tribes Technical College in Bismarck, North Dakota is the grantee of the Sacred Child Project. The grant proposed to develop a System of Care for children's mental health for four tribal groups,in North Dakota. The lessons learned from the children, families, and tribes involved with the project through the systems of care wraparound philosophy and methodology is the essence of this testimony. This document addresses Title VII-Behavioral Health Programs of the Act.

HISTORICAL LEGACY OF CHILD REMOVAL

Native American children have been removed from their families to be sent to boarding schools since the 1880's up to the 1950's. Youth continue to attend residential schools operated by the Bureau of Indian Affairs into the year 2000, although not to the extent as in previous eras. The early intention of this practice was to solve the "Indian problem". As we can now see in the year 2000, it was just the beginning of a problem perpetrated by individuals, many with good intentions, that began a nightmare of child removal for American Indian families. In 1886 the Commissioner of Indian Affairs stated,

> *" It is admitted by most people that the adult savage is not susceptible to the influence of civilization, and we must therefore turn to his children, that they might be taught to abandon the pathway of barbarism and walk with a sure step along the pleasant highway of Christian civilization"...*

This same removal policy was reiterated in the 1950's and 1960's after the closure of some of the boarding schools. This time it was in the form of Indian adoption and was voiced by state and county officials (George, 1997):

> *"If you want to solve the Indian problem you can do it in one generation. You can take all of our children of school age and move them bodily out to the Indian country and transport them to some other part of the United States. Where there are civilized people...If you take these kids away and educate them to make their own lives, they wouldn't come back here, . . ." (Rogers, 1950).*

The adoption movement was a success. It effectively continued the break-up of Indian families. The Association on American Indian Affairs conducted nationwide surveys on the placements of Native American children and found that 25% to 35% of all Native American children had been separated from their families. In 1971-1972, in Minnesota, one in four of all Native American infants under the age of one year old were placed for adoption. In 1978, the Indian Child Welfare Act was passed in order to protect encroachment on Indian children, their families, and their tribes.

After twenty years of the enactment of the Indian Child Welfare Act of 1978, there has not been a substantial decrease in the incidence of their removal from their families. Indian children are significantly over-represented in foster care and are three times more likely to be placed in foster care then a child from the general population n.

In some states, it is high as sixteen times more likely and in North Dakota, Indian children are eight times more likely to be placed in foster care then their non-Indian counterparts (Jones, 1999).

This phenomenon is a reflection of the substantial mental health and substance abuse problems, which in part have been exacerbated by U.S. policies that condoned the break up of Indian families as well as other traumas.

In North Dakota, Indian Children make up 7% of the child population under the age of 18 yet they are over-represented in the most restrictive environments in the state at alarming rates. For the past several years, Native American youth represent 35% to 50% of the population at the state Youth Correctional Center. Native youth are in group homes and residential therapeutic settings out of their communities over 35% of the resident population at any state or private facility. The use of BIA specialized schools for residential treatment is also reserved for those youth deemed to have special treatment needs. The practice of child removal from their Indian families and communities is now changing complexion as Indian youth are becoming a "treatment" population. Whatever the reason, the results are still the same, the removal of Indian children from their communities and families. The new trend is to solve the "Indian problem" by lock up in the name of "treatment and therapeutic intervention". This is a red flag to policy makers and lessons need to be learned from past experience.

SYSTEMS OF CARE

The Center for Mental Health Services, Children's Mental Health Division has granted Indian Tribes service demonstration grants to develop **Systems of Care** to provide community based interventions that are more cost effective and have better outcomes. A recently published Surgeon General Report on Mental Health states,

"The multiple problems associated with "serious emotional disturbance" in children and adolescence are best addressed with a "systems "approach in which multiple service sectors work in an organized, collaborative way. Research on the effectiveness of systems of care show positive results for system outcomes and functional outcomes for children."

This philosophy has been proven effective in many States and municipalities and is now just beginning to be embraced by a few CMHS funded tribes. The movement in Mental Health is to more community based services and the normalization and stabilization of children and adults with mental health needs in community settings. The deinstitutionalization of mental health practice is part of the United States history. In the last decade, the closing of an institution in North Dakota and the court ordering of community based placements in less restrictive environments has been mandated. It is with this history in mind that the Indian Health Care Improvement Act and subsequent implications for future impacts on Indian children and adults with mental health needs must be considered. Although acute hospitalization and therapeutic interventions in residential settings are critical in a good system of care, these should only be used as supports and not long term placements for children.

The Systems of Care philosophy also requires the collaboration and governance by all systems including education, juvenile justice, substance abuse, child welfare, and mental

health. One agency cannot do it all. These systems are also the places where Indian children are exiting their families and communities to become the next removal trend among Indian children. The Federal Bureau of Justice Reports that violent crimes committed by juveniles in Indian Country is extremely high, "of all juveniles in Federal Bureau of Prisons custody, 70% are Native American." What is wrong with this picture? What can Native Communities do to stop this trend? It can be logically argued that for all the generations of removal and trauma placed on Native youth by the United States government in the past 100 years, we are now experiencing several generations of untreated trauma which is now having an escalation effect. It is time to embrace the repatriation of Native American children.

Another shift in the paradigm is the concept of family driven planning. The saying, "never about us without us" embodies the family and child and their natural support people who are identified by them, sitting at the table as equal partners with the professionals from the agencies they are involved with. The movement to one plan rather then every agency doing their own thing promotes collaboration and better outcomes. The ownership by the child and family through the use of positive wraparound language promotes hope and respect for all team members. The outcomes are improved because they are chosen by the family as most likely to be effective from several options offered by all on the team. The epitome of this system of care approach is the blending of funds between agencies and acknowledged need to have flexible funds to meet the needs as identified by the team rather the just putting children and families in services that they may not want, may not fit their culture, and which they may in effect not need. This array of community based services and supports are so individualized to the family that they may be different or modified for all families. The Sacred Child Project, has been doing this in a process that is called WRAPAROUND. This is not a program or a service but a process by which all agencies and especially the child and family share a way by which they work together to meet the needs of the family. They speak the language of wraparound which they all understand. In three of the four tribes involved with the Sacred Child Project, the child welfare agencies have embraced the philosophy and have been certified as care coordinators capable of utilizing the wraparound process. The North Dakota Native American Counselors of Addictive Disorders, basically, the substance abuse professionals, have now voiced an interest to also be cross trained and certified in care coordination so that they can facilitate the wraparound process. In the one of the communities, school personnel have voiced interest in being certified as care coordinators in wraparound. The language and practice of wraparound is spreading among the varied professionals that comprise the key decision makers at the local level. In the Sacred Child Project, some parents themselves have been certified in care coordination and run their own meetings. The beauty of wraparound is that it can be used by any agency and many agencies in the same community and becomes the organizing methodology of the system of care. The Native American Children and Family Services Training Institute has provided technical assistance since the Sacred Child's inception and provides community training and care coordination certification in wraparound. This Training Institute is an inter-tribal entity governed by all the tribes in North Dakota. The five sites in the Sacred Child Project have been effective in setting up local teams with representatives of at a minimum seven people representing the best practice and local governance from child welfare, mental health, juvenile justice, education, and

substance abuse and families called the Wrap Around Intake Team (WRIT). This multidisciplinary team does enrollment and disenrollment for the project and coordinates resources and provides technical assistance on plans of care if necessary. Each tribe has their own WRIT. It is a multi-system way of providing what the mainstream calls "treatment plans". Each family has their own "child and family support team (CFST) that collaborates to develop the plans.

The experience of the Sacred Child Project indicates that there are no easy answers but rather the process by which the best of all worlds can meet and work in an established way to meet needs. It is much easier to provide routine services then it is to be innovative and really look at the situation and determine what will really works with the child and their family as equal partners. Wraparound is needs driven not service driven and the flexible funding is crucial to positive outcomes.
It is from this experience and practice that the following recommendations are made.

Recommendations:

- **Ensure that an array of community based services and supports are available and that out of community placement of any child is thoroughly analyzed.**

Be cognizant that because of the history of removal of Indian children and the historically limited access to mental health services, when asked what they need many tribes and parents have been conditioned to think that sending their kids away to long term therapeutic restrictive environments is "best practice". Research shows that when you have limited mental health services and supports in the community you are more likely to have a high level of out of home and community placements mostly because you lack a community array of services and supports and have limited experience with them.

- **Children and families must be included in the planning process.**

Any planning that is developed by tribes in the plans referred to in the legislation needs to reflect collaboration of the key players and especially the children and families. It is critical to involve the families of children with complex needs at every level of the system developed. This too is a system of care value.

- **Out of home therapeutic placements should be monitored closely.**

There needs to be stringent guidelines regarding the use of residential settings. The child needs to be stabilized and normalized and returned to the home and community environment as soon as possible. Monitoring of this is critical to prevent the abuses that are currently occurring regarding Indian children being warehoused in therapeutic settings for long periods of time with questionable outcomes. Placement of each child in a therapeutic out of community setting over 90 days should be thoroughly evaluated. This practice seems to solve the problems of adults who don't know what to do with children with complex and behavioral needs but does little to actually really help the child.

- **Flexible funding should be established with Bureau of Indian Affairs and Indian Health Service funding using systems of care standards.**

Barriers exist to collaboration that needs to take place regarding the blending of work and money between the Indian Health Service and Bureau of Indian Affairs. Case in point is the practice of the BIA social services to provide for room and board for Native youth to boarding schools and residential group homes and other residential facilities. Although this is sometimes necessary to help stabilize and normalize a child it is not a living arrangement. It is more natural to be raised in your own family and community. **Indian children need to be raised in their own families and communities.** It is very easy to find money to send a child out of the community to a placement, but very difficult to find money to help the child and family in the community. This is also complicated by child welfare eligibility requirements as well as other agencies' requirements. In a system of care, a child in need should enter the system at any point and still receive appropriate services and not the runaround of each agency deciding if they are eligible. In wraparound, those are details worked out as the child gets their needs met and as all the agencies work together on their team. Flexible funding helps to meet actual needs of the child. It is not always necessary to develop a whole service for everyone when what you need now is a simple approach to assist a specific family. This true collaboration would allow all agencies to share funds in the flexible funding pool and would sometimes be budget neutral. An example is that it may cost the Bureau of Indian Affairs $70,000 to send one child to a residential therapeutic school for 12 months. However, if the BIA was flexible enough to allow use the same money to help fund a special tutor aid in the school for the child and provide the family with some specialized supports, you could probably keep the child in the community for same or possibly even less money and you would have more positive outcomes. This concept of system of care is that the money should follow the child.

If this child is returned from this therapeutic school to their community, this same money should be available to support them at home. Perhaps this child wants to learn to grass dance and sing Indian and wants to attend sweats with their relatives as part of their plan of care. These opportunities would be lost by sending this child out of the community. This is what wraparound does: it utilizes the strengths of all the agencies, family members, culture and community to meet the real needs of the child. In a system of care approach, it would be critical for involved agencies to develop an agreement and guidelines of how they are going to use the flexible funds. Presently, the CMHS grant allows some limited flexible funds and the tribes in the Sacred Child Project themselves have contributed to their flex fund account. This is true collaboration. The Indian Health Services and Bureau of Indian Affairs need to authorize the use of some of their funds as flexible to make it possible to really meet the needs of families. The above scenario regarding the use of BIA social service room and board funds to do the reverse of keeping families together actually would not require extra revenues just flexibility in the use of the same funds.

The governance of this process in the **Sacred Child Project** lies with the Wraparound Review Intake Team. The child and family support team can use the

flexible funds only as they are agreed upon in the plans of care. Any expenditures over $500 need to be approved by the WRIT, who are essentially representing all the agencies involved. If any of the agencies know of other resources, and the families and communities themselves contribute the majority of the resources, they will use them first. This promotes individual self-sufficiency and collaboration. This really reflects the strengths of Indian culture. This use of informal supports has been the hallmark of the accomplishments of the effective outcomes being realized by the Sacred Child Project. The wraparound process as used in this project is truly needs driven not service driven. Vera Pina, a nationally well known wraparound consultant, commented to the staff at Sacred Child that she always refers to their project as truly needs driven since there were not very many services to plug people into to begin with. This experience has taught all involved to be very innovative in meeting needs. Another teaching has come from the children themselves. When asked what they wanted to help themselves many asked for learning more about their cultures and spirituality. It was not something they had to do. With very little costs, these families have tapped into the strengths of their own families and communities.

- **Cultural competence is letting the family have of voice and choice.**

It is necessary to insure cultural competence in the systems of care. This can only be accomplished by involving families and children at each level. Using strength based approaches are critical to this construct. It is only possible to be culturally competent if you ask the family well thought out questions that help them identify what strengths, preferences, and values they have as a family and individual in the family. If you assume that because they are Indian and you are from the same tribe that they automatically think and value what you do, you have already failed the competency test. Because you believe in Native American culture and spirituality, you assume that they should too. This may actually be a violation of their family or individual culture. Cautions to the policy makers is that although it is possible to promote Indian cultural practices and these have been most effective with many families in the Sacred Child Project, these were personal choices that were made by the individuals themselves. Mandating any type of component in essence would only be an extension of historically intrusive policies, but only in reverse. It is critical to let the families each lead in what it is that will work for them. When you do comprehensive assessments which are called strengths discoveries, then and only then can you help the family with the help of their team to use these strengths, values, and preferences to develop a plan that truly reflects their family and individual cultures. These positive values, activities, and ways of doing things as well as people that they already have in their lives are their culture and whatever else that is introduced as a tool needs to be congruent with their beliefs and feelings and must be agreed to by them. Mainstream mental health practice as usual is most likely not culturally competent under this definition.