

INDIAN HEALTH CARE IMPROVEMENT ACT

[Public Law 94–437; Approved September 30, 1976; 25 U.S.C. 1601 et seq.]

[As Amended Through P.L. 117–58, Enacted November 15, 2021]

【Currency: This publication is a compilation of the text of Public Law 94–437. It was last amended by the public law listed in the As Amended Through note above and below at the bottom of each page of the pdf version and reflects current law through the date of the enactment of the public law listed at <https://www.govinfo.gov/app/collection/comps/>】

【Note: While this publication does not represent an official version of any Federal statute, substantial efforts have been made to ensure the accuracy of its contents. The official version of Federal law is found in the United States Statutes at Large and in the United States Code. The legal effect to be given to the Statutes at Large and the United States Code is established by statute (1 U.S.C. 112, 204).】

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

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Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act". [25 U.S.C. 1601 note]

FINDINGS

SEC. 2. [25 U.S.C. 1601] The Congress finds the following:

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

(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.

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

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

(5) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

SEC. 3. [25 U.S.C. 1602] DECLARATION OF NATIONAL INDIAN HEALTH POLICY.

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

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

(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;

(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

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

(5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination;

(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

DEFINITIONS

SEC. 4. [25 U.S.C. 1603] In this Act:²

(1) **AREA OFFICE.**—The term “Area office” means 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.

(2) **BEHAVIORAL HEALTH.**—

(A) **IN GENERAL.**—The term “behavioral health” means the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

²Section 104(1) of S. 1790 of the 111th Congress (as reported and enacted into law by section 10221(a) of Public Law 111–148) provides for an amendment to section 4 “by striking the matter preceding subsection (a) and inserting ‘In this Act.’”. The amendment was carried out so that the section heading and designation, which appear in the matter preceding subsection (a), was not struck in order to reflect the probable intent of Congress.

- (B) INCLUSIONS.—The term “behavioral health” includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.
- (3) CALIFORNIA INDIAN.—The term “California Indian” means any Indian who is eligible for health services provided by the Service pursuant to section 809.
- (4) COMMUNITY COLLEGE.—The term “community college” means—
- (A) a tribal college or university; or
 - (B) a junior or community college.
- (5) CONTRACT HEALTH SERVICE.—The term “contract health service” means any health service that is—
- (A) delivered based on a referral by, or at the expense of, an Indian health program; and
 - (B) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.
- (6) DEPARTMENT.—The term “Department”, unless otherwise designated, means the Department of Health and Human Services.
- (7) DISEASE PREVENTION.—
- (A) IN GENERAL.—The term “disease prevention” means any activity for—
 - (i) the reduction, limitation, and prevention of—
 - (I) disease; and
 - (II) complications of disease; and
 - (ii) the reduction of consequences of disease.
 - (B) INCLUSIONS.—The term “disease prevention” includes an activity for—
 - (i) controlling—
 - (I) the development of diabetes;
 - (II) high blood pressure;
 - (III) infectious agents;
 - (IV) injuries;
 - (V) occupational hazards and disabilities;
 - (VI) sexually transmittable diseases; or
 - (VII) toxic agents; or
 - (ii) providing—
 - (I) fluoridation of water; or
 - (II) immunizations.
- (8) FAE.—The term “FAE” means fetal alcohol effect.
- (9) FAS.—The term “fetal alcohol syndrome” or “FAS” means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:
- (A) Central nervous system involvement such as mental retardation, 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.

(10) **HEALTH PROFESSION.**—The term “Health profession” means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

(11) **HEALTH PROMOTION.**—The term “health promotion” means any activity for—

(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness regarding health matters and enabling individuals to cope with health problems by increasing knowledge and providing valid information;

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

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

(D) making available safe water and sanitary facilities;

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

(F) promoting culturally competent care; and

(G) providing adequate and appropriate programs, including programs for—

(i) abuse prevention (mental and physical);

(ii) community health;

(iii) community safety;

(iv) consumer health education;

(v) diet and nutrition;

(vi) immunization and other methods of prevention of communicable diseases, including HIV/AIDS;

(vii) environmental health;

(viii) exercise and physical fitness;

(ix) avoidance of fetal alcohol spectrum disorders;

(x) first aid and CPR education;

(xi) human growth and development;

(xii) injury prevention and personal safety;

(xiii) behavioral health;

(xiv) monitoring of disease indicators between health care provider visits through appropriate means, including Internet-based health care management systems;

(xv) personal health and wellness practices;

(xvi) personal capacity building;

(xvii) prenatal, pregnancy, and infant care;

(xviii) psychological well-being;

(xix) reproductive health and family planning;

(xx) safe and adequate water;

(xxi) healthy work environments;

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

- (xxiii) stress control;
- (xxiv) substance abuse;
- (xxv) sanitary facilities;
- (xxvi) sudden infant death syndrome prevention;
- (xxvii) tobacco use cessation and reduction;
- (xxviii) violence prevention; and
- (xxix) such other activities identified by the Service, a tribal health program, or an urban Indian organization to promote achievement of any of the objectives referred to in section 3(2).

(12)³ INDIAN HEALTH PROGRAM.—The term “Indian health program” means—

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

(B) any tribal health program; and

(C) any Indian tribe or tribal organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 47) (commonly known as the “Buy Indian Act”).

(13) INDIANS OR INDIAN.—The term “Indians” or “Indian”, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102 and 103, such terms shall mean any individual who (A), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (B) is an Eskimo or Aleut or other Alaska Native, or (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.

(14) INDIAN TRIBE.—The term “Indian tribe” means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(15) JUNIOR OR COMMUNITY COLLEGE.—The term “junior or community college” has the meaning given the term in section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

(16) RESERVATION.—

(A) IN GENERAL.—The term “reservation” means a reservation, Pueblo, or colony of any Indian tribe.

(B) INCLUSIONS.—The term “reservation” includes—

- (i) former reservations in Oklahoma;
- (ii) Indian allotments; and

³Section 104(9) of S. 1790 of the 111th Congress (as reported and enacted into law by section 10221(a) of Public Law 111–148) provides for an amendment that strikes and replaces paragraph (12) with the text shown here. There was no paragraph (12) in law in order to strike.

(iii) Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

(17) SECRETARY.—The term “Secretary”, unless otherwise designated, means the Secretary of Health and Human Services.

(18) SERVICE.—The term “Service” means the Indian Health Service.

(19) SERVICE AREA.—The term “Service area” means the geographical area served by each area office.

(20) SERVICE UNIT.—The term “Service unit” means an administrative entity of the Service or a tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

(21) SUBSTANCE ABUSE.—The term “Substance abuse” includes inhalant abuse.

(22) TELEHEALTH.—The term “telehealth” has the meaning given the term in section 330K(a) of the Public Health Service Act (42 U.S.C. 254c–16(a)).

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

(24) TRIBAL COLLEGE OR UNIVERSITY.—The term “tribal college or university” has the meaning given the term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

(25) TRIBAL HEALTH PROGRAM.—The term “tribal health program” means an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(26) TRIBAL ORGANIZATION.—The term “tribal organization” has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(27) URBAN CENTER.—The term “Urban center” means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(28) URBAN INDIAN.—The term “Urban Indian” means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(29) 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 maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private en-

tities for the purpose of performing the activities described in section 503(a).

TITLE I—INDIAN HEALTH MANPOWER

PURPOSE

SEC. 101. [25 U.S.C. 1611] The purpose of this title is to increase the number of Indians entering the health professions and to assure an adequate supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health care to Indian people.

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 102. [25 U.S.C. 1612] (a) The Secretary, acting through the Service, shall make grants to public or nonprofit private health, or educational 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) of this subsection or who are undertaking training necessary to qualify them to enroll in any such course of study; or

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

(b)(1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe. The Secretary shall give a preference to applications submitted by Indian tribes or tribal organizations.

(2) The amount of any grant under this section shall be determined by the Secretary. Payments pursuant to grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary.

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

SEC. 103. [25 U.S.C. 1613] (a) The Secretary, acting through the Service, shall make scholarship grants 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) Scholarship grants made pursuant to this section shall be for the following purposes:

(1) Compensatory preprofessional education of any grantee, such scholarship not to exceed two years on a full-time basis (or the part-time equivalent thereof, as determined by the Secretary).

(2) Pregraduate education of any grantee 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 Secretary).

(c) Scholarship grants made under this section may cover costs of tuition, books, transportation, board, and other necessary related expenses of a grantee while attending school.

(d) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.

(e) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely by reason of such applicant's eligibility for assistance or benefits under any other Federal program.

INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

SEC. 104. [25 U.S.C. 1613a] (a) In order to provide health professionals to Indians, Indian tribes, tribal organizations, and urban Indian organizations, the Secretary, acting through the Service and in accordance with this section, shall make scholarship grants to Indians who are enrolled full or part time in appropriately accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l), except as provided in subsection (b) of this section.

(b)(1) The Secretary, acting through the Service, shall determine who shall receive scholarships under subsection (a) and shall determine the distribution of such scholarships among such health professions on the basis of the relative needs of Indians for additional service in such health professions.

(2) An individual 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).

(3)(A) 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 individual has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice, by service—

(i) in the Indian Health Service;

(ii) in a program conducted under a contract entered into under the Indian Self-Determination Act;

- (iii) in a program assisted under title V of this Act;⁴
- (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; or⁵
- (B) At the request of any individual 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 (v) of subparagraph (A).
- (C) A recipient of an Indian Health Scholarship may, at the election of the recipient, meet the active duty service obligation described in subparagraph (A) by service in a program specified in that subparagraph that—
- (i) is located on the reservation of the tribe in which the recipient is enrolled; or
 - (ii) serves the tribe in which the recipient is enrolled.
- (D) Subject to subparagraph (C), the Secretary, 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.
- (4) In the case of an individual 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 Secretary;
 - (B) the period of obligated service described in paragraph (3)(A) shall be equal to the greater of—

⁴ So in original. Should probably be followed by “or”.

⁵ So in original. The “; or” should probably be a period.

- (i) the part-time equivalent of one year for each year for which the individual was provided a scholarship (as determined by the Secretary); 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. 2541(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.
- (5)(A) An individual who has, on or after the date of the enactment of this paragraph, entered into a written contract with the Secretary under this section 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) is dismissed from such educational institution for disciplinary reasons,
 - (iii) voluntarily terminates the training in such an educational institution for which he 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 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 on his behalf, under the contract.
- (B) If for any reason not specified in subparagraph (A) an individual breaches his 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 (I) of section 108 in the manner provided for in such subsection.
- (C) 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) The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—
 - (i) it is not possible for the recipient to meet that obligation or make that payment;
 - (ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or
 - (iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.
- (E) 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) 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) The Secretary shall, acting through the Service, establish a Placement Office to develop and implement a national policy for the placement, to available vacancies within the Service, of Indian Health Scholarship recipients required to meet the active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) without regard to any competitive personnel system, agency personnel limitation, or Indian preference policy.

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105. [25 U.S.C. 1614] (a) Any individual who receives a scholarship grant pursuant to section 104 shall be entitled to employment in the service 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 grant.

(b) Any individual enrolled in a course of study in the health professions may be employed by the Service during any nonacademic period of the year. Any such employment shall not exceed one hundred and twenty days during any calendar year.

(c) Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department of Health and Human Services.

SEC. 106. [25 U.S.C. 1615] CONTINUING EDUCATION ALLOWANCES.

In order to encourage scholarship and stipend recipients under sections 104, 105, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in an Indian health program and to provide services in the rural and remote areas in which a significant portion of Indians reside, the Secretary, acting through the Service, may—

(1) provide programs or allowances to transition into an Indian health program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, and 115; and

(2) provide programs or allowances to health professionals employed in an Indian health program to enable those professionals, for a period of time each year prescribed by regulation of the Secretary, to take leave of the duty stations of the professionals for professional consultation, management, leadership, and refresher training courses.

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

SEC. 107. [25 U.S.C. 1616] (a) Under the authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary shall maintain a Community Health Representative Program under which the Service—

(1) provides for the training of Indians as health paraprofessionals, and

(2) uses such paraprofessionals in the provision of health care, health promotion, and disease prevention services to Indian communities.

(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—

(1) provide a high standard of training for paraprofessionals to 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 in the provision of health care, and

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

(3) maintain a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and 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.

INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM

SEC. 108. [25 U.S.C. 1616a] (a)(1) The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (hereinafter referred to 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) For the purposes of this section—

(A) 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 contract under—
 - (I) the Indian Self-Determination Act, or
 - (II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47), popularly known as the “Buy-Indian” Act; or
- (iii) by an urban Indian organization pursuant to title V of this Act; and
- (B) the term “State” has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.
- (b) 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)(1) 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) 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) 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)(1) Consistent with paragraph (3), 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) 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 of Indian tribes or tribal or Indian organizations.

(3)(A)⁶ Subject to subparagraph (B), of the total amounts appropriated for each of the fiscal years 1993, 1994, and 1995 for loan repayment contracts under this section, the Secretary shall provide that—

(i) not less than 25 percent be provided to applicants who are nurses, nurse practitioners, or nurse midwives; and

(ii) not less than 10 percent be provided to applicants who are mental health professionals (other than applicants described in clause (i)).

(B) The requirements specified in clause (i) or clause (ii) of subparagraph (A) shall not apply if the Secretary does not receive the number of applications from the individuals described in clause (i) or clause (ii), respectively, necessary to meet such requirements.

(e)(1) 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) The Secretary shall provide written notice to an individual promptly on—

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

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

(f) 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 or Indian organization as provided in subparagraph (B)(iii), and

⁶Margin for paragraph (3) so in law.

(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 (hereinafter in this section referred to as the “period of obligated service”) equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual’s profession in an Indian health program 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 (1) 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)(1) 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)(A) 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 deter-

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

(3) For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, the Secretary—

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

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

(4) 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) 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 of Health and Human Services.

(i) 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) 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) 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.

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

(B) 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) 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)(1) 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) 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) 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) 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) 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 104 with respect to each health profession;

(6) the amount of scholarship grants provided under section 104, 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 three 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 or tribal or Indian organizations for which recruitment or retention is difficult.

SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND

SEC. 108A. [25 U.S.C. 1616a–1] (a) There is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (hereafter in this section referred to as the “Fund”). The Fund shall consist of such amounts as may be appropriated to the Fund under subsection (b). Amounts appropriated for the Fund shall remain available until expended.

(b) For each fiscal year, there is authorized to be appropriated to the Fund an amount equal to the sum of—

(1) the amount collected during the preceding fiscal year by the Federal Government pursuant to—

(A) the liability of individuals under subparagraph (A) or (B) of section 104(b)(5) for the breach of contracts entered into under section 104; and

(B) the liability of individuals under section 108(l) for the breach of contracts entered into under section 108; and

(2) the aggregate amount of interest accruing during the preceding fiscal year on obligations held in the Fund pursuant to subsection (d) and the amount of proceeds from the sale or redemption of such obligations during such fiscal year.

(c)(1) Amounts in the Fund and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service, to make payments to an Indian tribe or tribal organization administering a health care program pursuant to a contract entered into under the Indian Self-Determination Act—

(A) to which a scholarship recipient under section 104 or a loan repayment program participant under section 108 has been assigned to meet the obligated service requirements pursuant to⁷ sections; and

(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 104 or section 108.

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

(d)(1) The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. 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) Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

⁷ So in original. Should probably be “to such”.

RECRUITMENT ACTIVITIES

SEC. 109. [25 U.S.C. 1616b] (a) The Secretary may reimburse health professionals seeking positions in the Service, including individuals considering entering into a contract under section 108, 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) 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.

TRIBAL RECRUITMENT AND RETENTION PROGRAM

SEC. 110. [25 U.S.C. 1616c] (a) The Secretary, acting through the Service, shall fund, on a competitive basis, projects to enable Indian tribes and tribal and Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 108(a)(2)).

(b)(1) Any Indian tribe or tribal or Indian organization may submit an application for funding of a project pursuant to this section.

(2) Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Determination Act shall be given an equal opportunity with programs that are administered directly by the Service to compete for, and receive, grants under subsection (a) for such projects.

ADVANCED TRAINING AND RESEARCH

SEC. 111. [25 U.S.C. 1616d] (a) The Secretary, acting through the Service, shall establish a program to enable health professionals to pursue advanced training or research in areas of study for which the Secretary determines a need exists. In selecting participants for a program established under this subsection, the Secretary, acting through the Service, shall give priority to applicants who are employed by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations, at the time of the submission of the applications.

(b) An individual who participates in a program under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program (as defined in section 108(a)(2)) for a period of obligated service equal to at least the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the program after the date of the enactment of the Indian Health Amendments of 1992, 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 108 in the manner provided for in such subsection.

(c) Health professionals from Indian tribes and tribal and Indian organizations under the authority of the Indian Self-Deter-

mination Act shall be given an equal opportunity to participate in the program under subsection (a).

NURSING PROGRAM

SEC. 112. [25 U.S.C. 1616e] (a) The Secretary, acting through the Service, shall provide grants 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)⁸), and
- (3) nurse midwife programs, and nurse practitioner programs, that are provided by any 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) Grants provided under subsection (a) may be used to—

- (1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or nurse practitioners,
- (2) provide scholarships to individuals enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses,
- (3) provide a program that encourages nurses, nurse midwives, and nurse practitioners 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 nurse practitioners, or
- (5) provide any program that is designed to achieve the purpose described in subsection (a).

(c) Each application for a grant under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

(d) In providing grants 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 nurse practitioners,
- (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 1988⁹.

(e) The Secretary shall provide one of the grants authorized under subsection (a) to establish and maintain a program at the

⁸Section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)) was omitted by Public Law 105-332. The definition used to read as follows: "The term 'tribally controlled postsecondary vocational institution' means an institution of higher education which is formally controlled, or has been formally sanctioned or chartered by the governing body of an Indian tribe or tribes which offers technical degrees or certificate granting programs."

⁹Section 5324 was repealed by section 1(b) of Public Law 105-332 on October 31, 1998 (112 Stat. 3076).

University of North Dakota to be known as the “Quentin N. Burdick American Indians Into Nursing Program”. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 114(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 217(b).

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

- (A) in the Indian Health Service;
 - (B) in a program conducted under a contract entered into under the Indian Self-Determination Act;
 - (C) in a program assisted under title V of this Act; or
 - (D) 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.
- (g) Beginning with fiscal year 1993, of the amounts appropriated under the authority of this title for each fiscal year to be used to carry out this section, not less than \$1,000,000 shall be used to provide grants under subsection (a) for the training of nurse midwives, nurse anesthetists, and nurse practitioners.

NURSING SCHOOL CLINICS

SEC. 112A. [25 U.S.C. 1616e–1] (a) GRANTS.—In addition to the authority of the Secretary under section 112(a)(1), the Secretary, acting through the Service, is authorized to provide grants to public or private schools of nursing for the purpose of establishing, developing, operating, and administering clinics to address the health care needs of Indians, and to provide primary health care services to Indians who reside on or within 50 miles of Indian country, as defined in section 1151 of title 18, United States Code.

(b) PURPOSES.—Grants provided under subsection (a) may be used to—

- (1) establish clinics, to be run and staffed by the faculty and students of a grantee school, to provide primary care services in areas in or within 50 miles of Indian country (as defined in section 1151 of title 18, United States Code);
- (2) provide clinical training, program development, faculty enhancement, and student scholarships in a manner that would benefit such clinics; and
- (3) carry out any other activities determined appropriate by the Secretary.

(c) AMOUNT AND CONDITIONS.—The Secretary may award grants under this section in such amounts and subject to such conditions as the Secretary deems appropriate.

(d) DESIGN.—The clinics established under this section shall be designed to provide nursing students with a structured clinical ex-

perience that is similar in nature to that provided by residency training programs for physicians.

(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

(f) AUTHORIZATION TO USE AMOUNTS.—Out of amounts appropriated to carry out this title for each of the fiscal years 1993 through 2000 not more than \$5,000,000 may be used to carry out this section.

TRIBAL CULTURE AND HISTORY

SEC. 113. [25 U.S.C. 1616f] (a) The Secretary, acting through the Service, shall establish a program under which appropriate employees of the Service who serve particular Indian tribes shall receive educational instruction in the history and culture of such tribes and in the history of the Service.

(b) To the extent feasible, the program established under subsection (a) shall—

(1) be carried out through tribally controlled colleges or universities (within the meaning of section 2(a)(4) of the Tribally Controlled Colleges and Universities Act of 1978) and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990¹⁰ (20 U.S.C. 2397h(2)),

(2) be developed in consultation with the affected tribal government, and

(3) include instruction in Native American studies.

INMED PROGRAM

SEC. 114. [25 U.S.C. 1616g] (a) The Secretary is authorized to provide grants to at least 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruitment program known as the “Indians into Medicine Program” (hereinafter in this section referred to as “INMED”) as a means of encouraging Indians to enter the health professions.

(b) The Secretary shall provide one of the grants authorized under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the “Quentin N. Burdick Indian Health Programs”, unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 217(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 112(e).

(c)(1) The Secretary shall develop regulations for the competitive awarding of the grants provided under this section.

¹⁰ Section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)) was omitted by Public Law 105–332. The definition used to read as follows: “The term ‘tribally controlled postsecondary vocational institution’ means an institution of higher education which is formally controlled, or has been formally sanctioned or chartered by the governing body of an Indian tribe or tribes which offers technical degrees or certificate granting programs.”

(2) Applicants for grants provided under this section shall agree to provide a program which—

(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.

(d) By no later than the date that is 3 years after the date of enactment of the Indian Health Care Amendments of 1988, the Secretary shall submit a report to the Congress on the program established under this section including recommendations for expansion or changes to the program.

HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES

SEC. 115. [25 U.S.C. 1616h] (a)(1) The Secretary, acting through the Service, shall award grants to community colleges for the purpose of assisting the community college in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on an Indian reservation or in a tribal clinic.

(2) 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)(1) The Secretary, acting through the Service, shall award grants to 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) Grants may only be made under this section to a community college which—

(A) is accredited,

(B) has access to 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 service unit facilities of the Service or at tribal health facilities,

(D) has a qualified staff which has the appropriate certifications, and

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

(c) 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) 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) For purposes of this section—

(1) The term “community college” means—

(A) a junior or community college that is a tribally controlled college or university, or

(B) a junior or community college.

(2) The term “tribally controlled college or university” has the meaning given to such term by section 2(a)(4) of the Tribally Controlled Colleges and Universities Assistance Act of 1978.

(3) The term “junior or community college” has the meaning given to such term by section 312(e) of the Higher Education Act of 1965¹¹ (20 U.S.C. 1058(e)).

ADDITIONAL INCENTIVES FOR HEALTH PROFESSIONALS

SEC. 116. [25 U.S.C. 1616i] (a) The Secretary may provide the incentive special pay authorized under section 302(b) or 335(b) of title 37, United States Code, to civilian medical officers of the Indian Health Service who are assigned to, and serving in, positions included in the list established under subsection (b)(1) for which recruitment or retention of personnel is difficult.

(b)(1) The Secretary shall establish and update on an annual basis a list of positions of health care professionals employed by, or assigned to, the Service for which recruitment or retention is difficult.

(2)(A) The Secretary may pay a bonus to any commissioned officer or civil service employee, other than a commissioned medical officer, dental officer, optometrist, and veterinarian, who is employed in or assigned to, and serving in, a position in the Service included in the list established by the Secretary under paragraph (1).

¹¹This definition is now found in section 312(f) of that Act (20 U.S.C. 1058(f)).

(B) The total amount of bonus payments made by the Secretary under this paragraph to any employee during any 1-year period shall not exceed \$2,000.

(c) The Secretary may establish programs to allow the use of flexible work schedules, and compressed work schedules, in accordance with the provisions of subchapter II of chapter 61 of title 5, United States Code, for health professionals employed by, or assigned to, the Service.

RETENTION BONUS

SEC. 117. [25 U.S.C. 1616j] (a) The Secretary may pay a retention bonus to any physician or nurse employed by, or assigned to, and serving in, the Service 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 included in the list established under section 116(b)(1) for which recruitment or retention of personnel is difficult,

(2) the Secretary determines is needed by the Service,

(3) has—

(A) completed 3 years of employment with the Service,

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 for continued employment for a period of not less than 1 year.

(b) Beginning with fiscal year 1993, not less than 25 percent of the retention bonuses awarded each year under subsection (a) shall be awarded to nurses.

(c) 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.

(d) The retention bonus for the entire period covered by the agreement described in subsection (a)(4) shall be paid at the beginning of the agreed upon term of service.

(e) Any physician or nurse 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 108(l)(2)(B).

(f) The Secretary may pay a retention bonus to any physician or nurse employed by an organization providing health care services to Indians pursuant to a contract under the Indian Self-Determination Act if such physician or nurse 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.

NURSING RESIDENCY PROGRAM

SEC. 118. [25 U.S.C. 1616k] (a) The Secretary, acting through the Service, shall establish a program to enable licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 108(a)(2)(A)), and have done so for a period of not less than one year, to pursue advanced training.

(b) Such program shall include a combination of education and work study in an Indian health program (as defined in section 108(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 a Master's degree.

(c) 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 at least three times the period of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 108 in the manner provided for in such subsection.

SEC. 119. [25 U.S.C. 1616l] COMMUNITY HEALTH AIDE PROGRAM.

(a) GENERAL PURPOSES OF PROGRAM.—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 develop and operate a Community Health Aide Program in the State of Alaska under which the Service—

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

(2) uses those 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 those villages for use by community health aides or community health practitioners.

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

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that those 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 regarding the theory of health care with supervised practical experience in the provision of health care;

(B) provides instruction and practical experience in the provision of acute care, emergency care, health pro-

motion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

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

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

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

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

(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to ensure the provision of quality health care, health promotion, and disease prevention services; and

(7) ensure that—

(A) pulpal therapy (not including pulpotomies on deciduous teeth) or extraction of adult teeth can be performed by a dental health aide therapist only after consultation with a licensed dentist who determines that the procedure is a medical emergency that cannot be resolved with palliative treatment; and

(B) dental health aide therapists are strictly prohibited from performing all other oral or jaw surgeries, subject to the condition that uncomplicated extractions shall not be considered oral surgery under this section.

(c) PROGRAM REVIEW.—

(1) NEUTRAL PANEL.—

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

(B) MEMBERSHIP.—Members of the neutral panel shall be appointed by the Secretary from among clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives.

(2) STUDY.—

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

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

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

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

(ii) the quality of care provided through those services, including any training, improvement, or additional oversight required to improve the quality of care; and

(iii) whether safer and less costly alternatives to the dental health aide therapist services exist.

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

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

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

(B) any comments received from Alaska tribal organizations under paragraph (2)(D).

(d) NATIONALIZATION OF PROGRAM.—

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

(2) REQUIREMENT; EXCLUSION.—Subject to paragraphs (3) and (4), in establishing a national program under paragraph (1), the Secretary—

(A) shall not reduce the amounts provided for the Community Health Aide Program described in subsections (a) and (b); and

(B) shall exclude dental health aide therapist services from services covered under the program.

(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.

(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist.

(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law.

MATCHING GRANTS TO TRIBES FOR SCHOLARSHIP PROGRAMS

SEC. 120. [25 U.S.C. 1616m] (a)(1) The Secretary shall make grants 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.

(2) Amounts available for grants under paragraph (1) for any fiscal year shall not exceed 5 percent of amounts available for such fiscal year for Indian Health Scholarships under section 104.

(3) An application for a grant under paragraph (1) shall be in such form and contain such agreements, assurances, and information as the Secretary determines are necessary to carry out this section.

(b)(1) An Indian tribe or tribal organization receiving a grant under subsection (a) shall agree to provide scholarships to Indians pursuing education in the health professions in accordance with the requirements of this section.

(2) With respect to the costs of providing any scholarship pursuant to paragraph (1)—

(A) 80 percent of the costs of the scholarship shall be paid from the grant made under subsection (a) to the Indian tribe or tribal organization; and

(B) 20 percent of such costs shall be paid from non-Federal contributions by the Indian tribe or tribal organization through which the scholarship is provided.

(3) In determining the amount of non-Federal contributions that have been provided for purposes of subparagraph (B) of paragraph (2), any amounts provided by the Federal Government to the Indian tribe or tribal organization involved or to any other entity shall not be included.

(4) Non-Federal contributions required by subparagraph (B) of paragraph (2) may be provided directly by the Indian tribe or tribal organization involved or through donations from public and private entities.

(c) An Indian tribe or tribal organization shall provide scholarships under subsection (b) only to Indians enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in section 104(a).

(d) In providing scholarships under subsection (b), the Secretary and the Indian tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

(1) obligate such recipient to provide service in an Indian health program (as defined in section 108(a)(2)(A)), in the same service area where the Indian tribe or tribal organization providing the scholarship is located, for—

(A) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent)

lent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

(B) such greater period of time as the recipient and the Indian tribe or tribal organization may agree;

(2) provide that the amount of such scholarship—

(A) may be expended only 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 338A(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

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

(3) require the recipient of such scholarship to maintain an acceptable level of academic standing (as determined by the educational institution in accordance with regulations issued by the Secretary); and

(4) require the recipient of such scholarship to meet the educational and licensure requirements necessary to be a physician, certified nurse practitioner, certified nurse midwife, or physician assistant.

(e)(1) An individual who has entered into a written contract with the Secretary and an Indian tribe or tribal organization under subsection (d) and who—

(A) 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),

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

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

(D) fails to accept payment, or instructs the educational institution in which he 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 on his behalf, under the contract.

(2) If for any reason not specified in paragraph (1), an individual breaches his written contract by failing either to begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (1) of section 108 in the manner provided for in such subsection.

(3) The Secretary may carry out this subsection on the basis of information submitted by the tribes or tribal organizations in-

volved, or on the basis of information collected through such other means as the Secretary determines to be appropriate.

(f) The recipient of a scholarship under subsection (b) shall agree, in providing health care pursuant to the requirements of subsection (d)(1)—

(1) not to discriminate against an individual seeking such 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 program established in title XIX of such Act; and

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

(g) The Secretary may not make any payments under subsection (a) to an Indian tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the Indian tribe or tribal organization has complied with requirements of this section.

TRIBAL HEALTH PROGRAM ADMINISTRATION

SEC. 121. [25 U.S.C. 1616n] The Secretary shall, by contract or otherwise, provide training for individuals in the administration and planning of tribal health programs.

UNIVERSITY OF SOUTH DAKOTA PILOT PROGRAM

SEC. 122. [25 U.S.C. 1616o] (a) The Secretary may make a grant to the School of Medicine of the University of South Dakota (hereafter in this section referred to as “USDSM”) to establish a pilot program on an Indian reservation at one or more service units in South Dakota to address the chronic manpower shortage in the Aberdeen Area of the Service.

(b) The purposes of the program established pursuant to a grant provided under subsection (a) are—

(1) to provide direct clinical and practical experience at a service unit to medical students and residents from USDSM and other medical schools;

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

(3) to provide academic and scholarly opportunities for physicians, physician assistants, nurse practitioners, nurses, and other allied health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

(c) The pilot program established pursuant to a grant provided under subsection (a) shall—

(1) incorporate a program advisory board composed of representatives from the tribes and communities in the area which will be served by the program; and

(2) shall be designated as an extension of the USDSM campus and program participants shall be under the direct supervision and instruction of qualified medical staff serving at the service unit who shall be members of the USDSM faculty.

(d) The USDSM shall coordinate the program established pursuant to a grant provided under subsection (a) with other medical schools in the region, nursing schools, tribal community colleges, and other health professional schools.

(e) The USDSM, in cooperation with the Service, shall develop additional professional opportunities for program participants on Indian reservations in order to improve the recruitment and retention of qualified health professionals in the Aberdeen Area of the Service.

SEC. 123. [25 U.S.C. 1616p] HEALTH PROFESSIONAL CHRONIC SHORT-AGE DEMONSTRATION PROGRAMS.

(a) **DEMONSTRATION PROGRAMS.**—The Secretary, acting through the Service, may fund demonstration programs for Indian health programs to address the chronic shortages of health professionals.

(b) **PURPOSES OF PROGRAMS.**—The purposes of demonstration programs under subsection (a) shall be—

(1) to provide direct clinical and practical experience within an Indian health program to health profession students and residents from medical schools;

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

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

(4) to provide training and support for alternative provider types, such as community health representatives, and community health aides.

(c) **ADVISORY BOARD.**—The demonstration programs established pursuant to subsection (a) shall incorporate a program advisory board, which may be composed of representatives of tribal governments, Indian health programs, and Indian communities in the areas to be served by the demonstration programs.

SEC. 124. [25 U.S.C. 1616q] EXEMPTION FROM PAYMENT OF CERTAIN FEES.

Employees of a tribal health program or urban Indian organization shall be exempt from payment of licensing, registration, and any other fees imposed by a Federal agency to the same extent that officers of the commissioned corps of the Public Health Service and other employees of the Service are exempt from those fees.

TITLE II—HEALTH SERVICES

SEC. 201. [25 U.S.C. 1621] INDIAN HEALTH CARE IMPROVEMENT FUND.

(a) **USE OF FUNDS.**—The Secretary, acting through the Service, is authorized to expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act (25

U.S.C. 450 et seq.), which are appropriated under the authority of this section, for the purposes of—

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

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

(3) meeting the health needs of Indians in an efficient and equitable manner, including the use of telehealth and telemedicine when appropriate;

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

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

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

(B) Preventive health, including mammography and other cancer screening.

(C) Dental care.

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

(E) Emergency medical services.

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

(G) Injury prevention programs, including data collection and evaluation, demonstration projects, training, and capacity building.

(H) Home health care.

(I) Community health representatives.

(J) Maintenance and improvement.

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

(c) **ALLOCATION; USE.**—

(1) **IN GENERAL.**—Funds appropriated under the authority of this section shall be allocated to Service units, Indian tribes, or tribal organizations. The funds allocated to each Indian tribe, tribal organization, or Service unit under this paragraph shall be used by the Indian tribe, tribal organization, or Service unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian tribe served by such Service unit, Indian tribe, or tribal organization.

(2) **APPORTIONMENT OF ALLOCATED FUNDS.**—The apportionment of funds allocated to a Service unit, Indian tribe, or tribal organization under paragraph (1) among the health service re-

sponsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes and tribal organizations.

(d) PROVISIONS RELATING TO HEALTH STATUS AND RESOURCE DEFICIENCIES.—For the purposes of this section, the following definitions apply:

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

(A) the health status objectives set forth in sections 3(1) and 3(2) are not being achieved; and

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

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

(3) PROCESS FOR REVIEW OF DETERMINATIONS.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such Indian tribe or tribal organization.

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

(f) REPORT.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for each Service unit, including newly recognized or acknowledged Indian tribes. Such report shall set out—

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

(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service or a tribal health program;

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

(4) an estimate of—

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

(B) the number of Indians eligible for health services in each Service unit or Indian tribe or tribal organization; and

(C) the number of Indians using the Service resources made available to each Service unit, Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

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

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

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

SEC. 202. [25 U.S.C. 1621a] CATASTROPHIC HEALTH EMERGENCY FUND.

(a) ESTABLISHMENT.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the “CHEF”) consisting of—

- (1) the amounts deposited under subsection (f); and
- (2) the amounts appropriated to CHEF under this section.

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

(c) CONDITIONS ON USE OF FUND.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

(d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provisions of this section to—

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

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

(A) the 2000 level of \$19,000; and

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

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

(A) Service Units; or

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

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

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

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

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

HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

SEC. 203. [25 U.S.C. 1621b] (a) The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians so as to achieve the health status objectives set forth in section 3(b).

(b) The Secretary shall submit to the President for inclusion in each statement which is required to be submitted to the 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. [25 U.S.C. 1621c] DIABETES PREVENTION, TREATMENT, AND CONTROL.

(a) **DETERMINATIONS REGARDING DIABETES.**—The Secretary, acting through the Service, and in consultation with Indian tribes and tribal organizations, shall determine—

(1) by Indian tribe and by Service unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

(2) based on the determinations made pursuant to paragraph (1), the measures (including patient education and effec-

tive ongoing monitoring of disease indicators) each Service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that Service unit.

(b) **DIABETES SCREENING.**—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of disease indicators. Such screening and monitoring may be conducted by a tribal health program and may be conducted through appropriate Internet-based health care management programs.

(c) **DIABETES PROJECTS.**—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, any such other diabetes programs operated by the Service or tribal health programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian tribes. tribal health programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 and for projects which are added and funded thereafter.

(d) **DIALYSIS PROGRAMS.**—The Secretary is authorized to provide, through the Service, Indian tribes, and tribal organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

(e) **OTHER DUTIES OF THE SECRETARY.**—

(1) **IN GENERAL.**—The Secretary shall, to the extent funding is available—

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

(B) establish in each area office a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area; and

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

(2) **DIABETES CONTROL OFFICERS.**—

(A) **IN GENERAL.**—The Secretary may establish and maintain in each area office a position of diabetes control officer to coordinate and manage any activity of that area office relating to the prevention, treatment, or control of diabetes to assist the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254c–3).

(B) **CERTAIN ACTIVITIES.**—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450

et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

SEC. 205. [25 U.S.C. 1621d] OTHER AUTHORITY FOR PROVISION OF SERVICES.

(a) **DEFINITIONS.**—In this section:

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

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

(B) shall meet all applicable standards for licensure.

(2) **HOME- AND COMMUNITY-BASED SERVICE.**—The term “home- and community-based service” means 1 or more of the services specified in paragraphs (1) through (9) of section 1929(a) of the Social Security Act (42 U.S.C. 1396t(a)) (whether provided by the Service or by an Indian tribe or tribal organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) that are or will be provided in accordance with applicable standards.

(3) **HOSPICE CARE.**—The term “hospice care” means—

(A) 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

(B) such other services as an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of that care.

(4) **LONG-TERM CARE SERVICES.**—The term “long-term care services” has the meaning given the term “qualified long-term care services” in section 7702B(c) of the Internal Revenue Code of 1986.

(b) **FUNDING AUTHORIZED.**—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objectives set forth in section 3 through health care-related services and programs not otherwise described in this Act for the following services:

(1) Hospice care.

(2) Assisted living services.

(3) Long-term care services.

(4) Home- and community-based services.

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

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

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

(3) Such other individuals as an applicable tribal health program determines to be appropriate.

(d) **AUTHORIZATION OF CONVENIENT CARE SERVICES.**—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may also provide funding under this Act to meet the objec-

tives set forth in section 3 for convenient care services programs pursuant to section 307(c)(2)(A).

SEC. 206. [25 U.S.C. 1621e] REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

(a) **RIGHT OF RECOVERY.**—Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—

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

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

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

(1) workers' compensation laws; or

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

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

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

(e) **ENFORCEMENT.**—

(1) **IN GENERAL.**—The United States, an Indian tribe, or tribal organization may enforce the right of recovery provided under subsection (a) by—

(A) intervening or joining in any civil action or proceeding brought—

(i) by the individual for whom health services were provided by the Secretary, an Indian tribe, or tribal organization; or

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

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

(2) NOTICE.—All reasonable efforts shall be made to provide notice of action instituted under paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

(3) RECOVERY FROM TORTFEASORS.—

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

(B) TREATMENT.—The right of an Indian tribe or tribal organization to recover under subparagraph (A) shall be independent of the rights of the injured or diseased person served by the Indian tribe or tribal organization.

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

(g) COSTS AND ATTORNEY'S FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded its reasonable attorney's fees and costs of litigation.

(h) NONAPPLICABILITY OF CLAIMS FILING REQUIREMENTS.—An insurance company, health maintenance organization, self-insurance plan, managed care plan, or other health care plan or program (under the Social Security Act or otherwise) may not deny a claim for benefits submitted by the Service or by an Indian tribe or tribal organization based on the format in which the claim is submitted if such format complies with the format required for sub-

mission of claims under title XVIII of the Social Security Act or recognized under section 1175 of such Act.

(i) **APPLICATION TO URBAN INDIAN ORGANIZATIONS.**—The previous provisions of this section shall apply to urban Indian organizations with respect to populations served by such Organizations in the same manner they apply to Indian tribes and tribal organizations with respect to populations served by such Indian tribes and tribal organizations.

(j) **STATUTE OF LIMITATIONS.**—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section, and the references therein to the United States are deemed to include Indian tribes, tribal organizations, and urban Indian organizations.

(k) **SAVINGS.**—Nothing in this section shall be construed to limit any right of recovery available to the United States, an Indian tribe, or tribal organization under the provisions of any applicable, Federal, State, or tribal law, including medical lien laws.

SEC. 207. [25 U.S.C. 1621f] CREDITING OF REIMBURSEMENTS.

(a) **USE OF AMOUNTS.**—

(1) **RETENTION BY PROGRAM.**—Except as provided in sections 202(a)(2) and 813, all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 813, by reason of the provision of health services by the Service, by an Indian tribe or tribal organization, or by an urban Indian organization, shall be credited to the Service, such Indian tribe or tribal organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

(2) **PROGRAMS COVERED.**—The programs referred to in paragraph (1) are the following:

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

(B) This Act, including section 813.

(C) Public Law 87–693.

(D) Any other provision of law.

(b) **NO OFFSET OF AMOUNTS.**—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

CREDITING OF REIMBURSEMENTS

SEC. 207. (a) Except as provided in section 202(d), title IV, and section 813 of this Act, all reimbursements received or recovered, under authority of this Act, Public Law 87–693 (42 U.S.C. 2651, et seq.), or any other provision of law, by reason of the provision of health services by the Service or by a tribe or tribal organization under a contract pursuant to the Indian Self-Determination Act 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) The Service may not offset or limit the amount of funds obligated to any service unit or any entity under contract with the Service because of the receipt of reimbursements under subsection (a).

HEALTH SERVICES RESEARCH

SEC. 208. [25 U.S.C. 1621g] Of the amounts appropriated for the Service in any fiscal year, other than amounts made available for the Indian Health Care Improvement Fund, not less than \$200,000 shall be available only for research to further the performance of the health service responsibilities of the Service. Indian tribes and tribal organizations contracting with the Service under the authority of the Indian Self-Determination Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

MENTAL HEALTH PREVENTION AND TREATMENT SERVICES

SEC. 209. [25 U.S.C. 1621h] (a) NATIONAL PLAN FOR INDIAN MENTAL HEALTH SERVICES.—(1) Not later than 120 days after the date of enactment of this section, the Secretary, acting through the Service, shall develop and publish in the Federal Register a final national plan for Indian Mental Health Services. The plan shall include—

(A) an assessment of the scope of the problem of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians, including—

(i) the number of Indians served by the Service 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; and

(C) an estimate of the additional funding needed by the Service to meet its responsibilities under the plan.

(2) The Secretary shall submit a copy of the national plan to the Congress.

(b) MEMORANDUM OF AGREEMENT.—Not later than 180 days after the date of enactment of this section, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement under which the Secretaries shall, among other things—

(1) determine and define the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

(2) make an assessment of the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

(3) make an initial determination of the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

(4)(A) ensure that Indians, as citizens of the United States and of the States in which they reside, have access to mental health services to which all citizens have access;

(B) determine the right of Indians to participate in, and receive the benefit of, such services; and

(C) take actions necessary to protect the exercise of such right;

(5) delineate 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) provide 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 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-diagnosed 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 subsection (d); and

(8) provide for an annual review of such agreement by the two Secretaries.

(c) **COMMUNITY MENTAL HEALTH PLAN.**—(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a community mental health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members.

(2) 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 tribe in the development of such plan. Upon the establishment of such a plan and at the request of the tribe, such officials, as directed by the memorandum of agreement developed pursuant to subsection (c), shall cooperate with the tribe in the implementation of such plan.

(3) Two or more Indian tribes may form a coalition for the adoption of resolutions and the establishment and development of a joint community mental health plan under this subsection.

(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community mental health plan and to provide administrative support in the implementation of such plan.

(d) BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.—

(1) STUDY; LIST.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian tribes and tribal organizations, shall conduct a study and compile a list of the types of staff positions specified in paragraph (2) whose qualifications include, or should include, training in the identification, prevention, education, referral, or treatment of mental illness, or dysfunctional and 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 and 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 identified in subparagraphs (A) and (B) established and maintained by Indian tribes and tribal organizations (without regard to the funding source).

(3) TRAINING CRITERIA.—

(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in paragraphs (2)(A) and (2)(B) and ensure that appropriate training has been, or shall be provided to any individual in any such position. With respect to any such individual in a position identified pursuant to paragraph (2)(C), the respective Secretaries shall provide appropriate training to, or provide funds to, an Indian tribe or tribal organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

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

(4) COMMUNITY EDUCATION ON MENTAL ILLNESS.—The Service shall develop and implement, on request of an Indian tribe, tribal organization, or urban Indian organization, or as

sist the Indian tribe, tribal organization, or urban Indian organization to develop and implement, a program of community education on mental illness. In carrying out this paragraph, the Service shall, upon request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

(5) PLAN.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall develop a plan under which the Service will increase the health care staff providing behavioral health services by at least 500 positions within 5 years after the date of enactment of that Act, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this paragraph shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the “Snyder Act”).

(e) STAFFING.—(1) Within 90 days after the date of enactment of this section, the Secretary shall develop a plan under which the Service will increase the health care staff providing mental health services by at least 500 positions within five years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level for services which shall include outpatient, emergency, aftercare and follow-up, and prevention and education services.

(2) The plan developed under paragraph (1) shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) popularly known as the “Snyder Act”.

(f) STAFF RECRUITMENT AND RETENTION.—(1) The Secretary shall provide for the recruitment of the additional personnel required by subsection (f) and the retention of all Service personnel providing mental health services. In carrying out this subsection, the Secretary shall give priority to practitioners providing mental health services to children and adolescents with mental health problems.

(2) In carrying out paragraph (1), the Secretary shall develop a program providing for—

(A) the payment of bonuses (which shall not be more favorable than those provided for under sections 116 and 117) for service in hardship posts;

(B) the repayment of loans (for which the provisions of repayment contracts shall not be more favorable than the repayment contracts under section 108) for health professions education as a recruitment incentive; and

(C) a system of postgraduate rotations as a retention incentive.

(3) This subsection shall be carried out in coordination with the recruitment and retention programs under title I.

(g) MENTAL HEALTH TECHNICIAN PROGRAM.—(1) Under the authority of the Snyder Act of November 2, 1921 (25 U.S.C. 13), the

Secretary shall establish and maintain a Mental Health Technician program within the Service which—

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

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

(2) In carrying out paragraph (1)(A), 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.

(3) The Secretary shall supervise and evaluate the mental health technicians in the training program.

(4) The Secretary shall ensure that the program established pursuant to this subsection involves the utilization and promotion of the traditional Indian health care and treatment practices of the Indian tribes to be served.

(h) MENTAL HEALTH RESEARCH.—The Secretary, acting through the Service and in consultation with the National Institute of Mental Health, shall enter into contracts with, or make grants to, appropriate institutions for the conduct of research on the incidence and prevalence of mental disorders among Indians on Indian reservations and in urban areas. Research priorities under this subsection shall include—

(1) the inter-relationship and inter-dependence of mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence, and

(2) the development of models of prevention techniques.

The effect of the inter-relationships and interdependencies referred to in paragraph (1) on children, and the development of prevention techniques under paragraph (2) applicable to children, shall be emphasized.

(i) FACILITIES ASSESSMENT.—Within one year after the date of enactment of this section, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

(j) ANNUAL REPORT.—The Service shall develop methods for analyzing and evaluating the overall status of mental health programs and services for Indians and shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report on the mental health status of Indians which shall describe the progress being made to address mental health problems of Indian communities.

(k) MENTAL HEALTH DEMONSTRATION GRANT PROGRAM.—(1) The Secretary, acting through the Service, is authorized to make grants to Indian tribes and inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs to

deliver innovative community-based mental health services to Indians. The 25 percent tribal share of such cost may be provided in cash or through the provision of property or services.

(2) The Secretary may award a grant for a project under paragraph (1) to an Indian tribe or inter-tribal consortium which meets the following criteria:

(A) The project will address significant unmet mental health needs among Indians.

(B) The project will serve a significant number of Indians.

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

(D) The tribe or consortium has the administrative and financial capability to administer the project.

(E) The project will deliver services in a manner consistent with traditional Indian healing and treatment practices.

(F) The project is coordinated with, and avoids duplication of, existing services.

(3) For purposes of this subsection, the Secretary shall, in evaluating applications for grants for projects to be operated under any contract entered into with the Service under the Indian Self-Determination Act, use the same criteria that the Secretary uses in evaluating any other application for such a grant.

(4) The Secretary may only award one grant under this subsection with respect to a service area until the Secretary has awarded grants for all service areas with respect to which the Secretary receives applications during the application period, as determined by the Secretary, which meet the criteria specified in paragraph (2).

(5) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a report evaluating the effectiveness of the innovative community-based projects demonstrated pursuant to this subsection. Such report shall include findings and recommendations, if any, relating to the reorganization of the programs of the Service for delivery of mental health services to Indians.

(6) Grants made pursuant to this section may be expended over a period of three years and no grant may exceed \$1,000,000 for the fiscal years involved.

(1) LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.—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 contract pursuant to the Indian Self-Determination Act shall—

(1) in the case of a person employed as a psychologist, be licensed as a clinical psychologist or working under the direct supervision of a licensed clinical 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.

pist or working under the direct supervision of a licensed marriage and family therapist.

(m) INTERMEDIATE ADOLESCENT MENTAL HEALTH SERVICES.—

(1) The Secretary, acting through the Service, may make grants to Indian tribes and tribal organizations to provide intermediate mental health services to Indian children and adolescents, including—

- (A) inpatient and outpatient services;
- (B) emergency care;
- (C) suicide prevention and crisis intervention; and
- (D) prevention and treatment of mental illness, and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) Funds provided under this subsection may be used—

- (A) to construct or renovate an existing health facility to provide intermediate mental health services;
- (B) to hire mental health professionals;
- (C) to staff, operate, and maintain an intermediate mental health facility, group home, or youth shelter where intermediate mental health services are being provided; and
- (D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units.

(3) Funds provided under this subsection may not be used for the purposes described in section 216(b)(1).

(4) An Indian tribe or tribal organization receiving a grant under this subsection shall ensure that intermediate adolescent mental health services are coordinated with other tribal, Service, and Bureau of Indian Affairs mental health, alcohol and substance abuse, and social services programs on the reservation of such tribe or tribal organization.

(5) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this subsection.

MANAGED CARE FEASIBILITY STUDY

SEC. 210. [25 U.S.C. 1621i] (a) The Secretary, acting through the Service, shall conduct a study to assess the feasibility of allowing an Indian tribe to purchase, directly or through the Service, managed care coverage for all members of the tribe from—

- (1) a tribally owned and operated managed care plan; or
- (2) a State licensed managed care plan.

(b) Not later than the date which is 12 months after the date of the enactment of this section, the Secretary shall transmit to the Congress a report containing—

- (1) a detailed description of the study conducted pursuant to this section; and
- (2) a discussion of the findings and conclusions of such study.

CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM

SEC. 211. [25 U.S.C. 1621j] (a) The Secretary shall establish a demonstration program to evaluate the use of a contract care intermediary to improve the accessibility of health services to California Indians.

(b)(1) In establishing such program, 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, during the period of the demonstration program, 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 810 with respect to high-cost contract care cases.

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

(3) No payment may be made for treatment provided under the demonstration program to the extent 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) There is hereby established an advisory board which shall advise the California Rural Indian Health Board in carrying out the demonstration pursuant to 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 such demonstration, at least one half of whom are not affiliated with the California Rural Indian Health Board.

(d) The demonstration program described in this section shall begin on January 1, 1993, and shall terminate on September 30, 1997.

(e) Not later than July 1, 1998, the California Rural Indian Health Board shall submit to the Secretary a report on the demonstration program carried out under this section, including a statement of its findings regarding the impact of using a contract care intermediary on—

- (1) access to needed health services;
- (2) waiting periods for receiving such services; and
- (3) the efficient management of high-cost contract care cases.

(f) For the purposes of this section, the term “high-cost contract care cases” means those cases in which the cost of the medical treatment provided to an individual—

- (1) would otherwise be eligible for reimbursement from the Catastrophic Health Emergency Fund established under section 202, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 202(b)(2); and
- (2) exceeds \$1,000.

COVERAGE OF SCREENING MAMMOGRAPHY

SEC. 212. [25 U.S.C. 1621k] The Secretary, through the Service, shall provide for screening mammography (as defined in section 1861(jj) of the Social Security Act) for Indian and urban Indian women 35 years of age or older at a frequency, determined by the

Secretary (in consultation with the Director of the National Cancer Institute), appropriate to such women, 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 and other cancer screenings.

SEC. 213. [25 U.S.C. 16211] PATIENT TRAVEL COSTS.

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

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

(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

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

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

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

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

SEC. 214. [25 U.S.C. 1621m] EPIDEMIOLOGY CENTERS.

(a) **ESTABLISHMENT OF CENTERS.**—

(1) **IN GENERAL.**—The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in subsection (b).

(2) **NEW CENTERS.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), any new center established after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 may be operated under a grant authorized by subsection (d).

(B) **REQUIREMENT.**—Funding provided in a grant described in subparagraph (A) shall not be divisible.

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

(b) **FUNCTIONS OF CENTERS.**—In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian tribes, tribal organizations, and urban Indian organizations in the Service area;

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

(3) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

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

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

(6) provide requested technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

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

(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out this section.

(d) GRANTS FOR STUDIES.—

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

(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization shall be eligible to receive a grant under this subsection if the intertribal consortium is—

(A) incorporated for the primary purpose of improving Indian health; and

(B) representative of the Indian tribes or urban Indian communities residing in the area in which the intertribal consortium is located.

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

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

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

(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

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

- (A) to carry out the functions described in subsection (b);
 - (B) to provide information to, and consult with, tribal leaders, urban Indian community leaders, and related health staff regarding health care and health service management issues; and
 - (C) in collaboration with Indian tribes, tribal organizations, and urban Indian organizations, to provide to the Service information regarding ways to improve the health status of Indians.
- (e) ACCESS TO INFORMATION.—
- (1) IN GENERAL.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority (as defined in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation)) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).
- (2) ACCESS TO INFORMATION.—The Secretary shall grant to each epidemiology center described in paragraph (1) access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.
- (3) REQUIREMENT.—The activities of an epidemiology center described in paragraph (1) shall be for the purposes of research and for preventing and controlling disease, injury, or disability (as those activities are described in section 164.512 of title 45, Code of Federal Regulations (or a successor regulation)), for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191¹²; 110 Stat. 1936).

COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS

SEC. 215. [25 U.S.C. 1621n] (a) The Secretary, acting through the Service and in consultation with the Secretary of the Interior, may award grants to Indian tribes to develop comprehensive school health education programs for children from preschool through grade 12 in schools located on Indian reservations.

- (b) Grants awarded under this section may be used to—
- (1) develop health education curricula;
 - (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, and fitness;
 - (7) develop mental health wellness programs;
 - (8) develop chronic disease prevention programs;
 - (9) develop substance abuse prevention programs;

¹²So in law. A space should appear after “Public Law” and before “104–191”.

(10) develop accident prevention and safety education programs;

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

(12) develop community and environmental health education programs.

(c) The Secretary shall provide technical assistance to Indian tribes in the development of health education plans, and the dissemination of health education materials and information on existing health programs and resources.

(d) The Secretary shall establish criteria for the review and approval of applications for grants made pursuant to this section.

(e) Recipients of grants under this section shall submit to the Secretary an annual report on activities undertaken with funds provided under this section. Such reports shall include a statement of—

(1) the number of preschools, elementary schools, and secondary schools served;

(2) the number of students served;

(3) any new curricula established with funds provided under this section;

(4) the number of teachers trained in the health curricula; and

(5) the involvement of parents, members of the community, and community health workers in programs established with funds provided under this section.

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

(2) Such program shall include—

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

(B) mental health wellness programs;

(C) chronic disease prevention programs;

(D) substance abuse prevention programs;

(E) accident prevention and safety education programs; and

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

(3) 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.

(g) There are authorized to be appropriated to carry out this section \$15,000,000 for fiscal year 1993 and such sums as may be necessary for each of the fiscal years 1994, 1995, 1996, 1997, 1998, 1999, and 2000.

INDIAN YOUTH GRANT PROGRAM

SEC. 216. [25 U.S.C. 1621o] (a) The Secretary, acting through the Service, is authorized to make grants to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian preadolescent and adolescent youths.

(b)(1) 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 healers; and

(B) develop and provide community training and education.

(2) Funds made available under this section may not be used to provide services described in section 708(c).

(c) The Secretary shall—

(1) disseminate to Indian tribes 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, provide technical assistance in the implementation of such models.

(d) The Secretary shall establish criteria for the review and approval of applications under this section.

SEC. 217. [25 U.S.C. 1621p] AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than \$300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at various locations throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

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

(c) REGULATIONS.—The Secretary shall issue regulations pursuant to this Act for the competitive awarding of grants provided under this section.

(d) CONDITIONS OF GRANT.—Applicants under this section shall agree to provide a program which, at a minimum—

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

and accredited and accessible community colleges that will be served by the program;

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

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

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

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

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

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

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

(1) in an Indian health program;

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

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

(f) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section \$2,700,000 for fiscal year 2010 and each fiscal year thereafter.

SEC. 218. [25 U.S.C. 1621q] PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

(a) **GRANTS AUTHORIZED.**—The Secretary, acting through the Service, and after consultation with the Centers for Disease Control and Prevention, may make grants available to Indian tribes and tribal organizations for the following:

(1) Projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncytial virus, hanta virus, sexually transmitted diseases, and *H. pylori*.

(2) Public information and education programs for the prevention, control, and elimination of communicable and infectious diseases.

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

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

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

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

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

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

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

CONTRACT HEALTH SERVICES PAYMENT STUDY

SEC. 219. [25 U.S.C. 1621r] (a) The Secretary, acting through the Service and in consultation with representatives of Indian tribes and tribal organizations operating contract health care programs under the Indian Self-Determination Act (25 U.S.C. 450f et seq.) or under self-governance compacts, Service personnel, private contract health services providers, the Indian Health Service Fiscal Intermediary, and other appropriate experts, shall conduct a study—

(1) to assess and identify administrative barriers that hinder the timely payment for services delivered by private contract health services providers to individual Indians by the Service and the Indian Health Service Fiscal Intermediary;

(2) to assess and identify the impact of such delayed payments upon the personal credit histories of individual Indians who have been treated by such providers; and

(3) to determine the most efficient and effective means of improving the Service's contract health services payment system and ensuring the development of appropriate consumer protection policies to protect individual Indians who receive authorized services from private contract health services providers from billing and collection practices, including the development of materials and programs explaining patients' rights and responsibilities.

(b) The study required by subsection (a) shall—

(1) assess the impact of the existing contract health services regulations and policies upon the ability of the Service and the Indian Health Service Fiscal Intermediary to process, on a timely and efficient basis, the payment of bills submitted by private contract health services providers;

(2) assess the financial and any other burdens imposed upon individual Indians and private contract health services providers by delayed payments;

(3) survey the policies and practices of collection agencies used by contract health services providers to collect payments for services rendered to individual Indians;

(4) identify appropriate changes in Federal policies, administrative procedures, and regulations, to eliminate the problems experienced by private contract health services providers and individual Indians as a result of delayed payments; and

(5) compare the Service's payment processing requirements with private insurance claims processing requirements to evaluate the systemic differences or similarities employed by the Service and private insurers.

(c) Not later than 12 months after the date of the enactment of this section, the Secretary shall transmit to the Congress a report that includes—

(1) a detailed description of the study conducted pursuant to this section; and

(2) a discussion of the findings and conclusions of such study.

PROMPT ACTION ON PAYMENT OF CLAIMS

SEC. 220. [25 U.S.C. 1621s] (a) 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) 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) The Service shall pay a completed contract care service claim within 30 days after completion of the claim.

SEC. 221. [25 U.S.C. 1621t] LICENSING.

Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

SEC. 222. [25 U.S.C. 1621u] LIABILITY FOR PAYMENT.

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

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

(c) **NO RECOURSE.**—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the services.

SEC. 223. [25 U.S.C. 1621v] OFFICES OF INDIAN MEN'S HEALTH AND INDIAN WOMEN'S HEALTH.

(a) **OFFICE OF INDIAN MEN'S HEALTH.**—

(1) **ESTABLISHMENT.**—The Secretary may establish within the Service an office, to be known as the “Office of Indian Men’s Health”.

(2) **DIRECTOR.**—

(A) **IN GENERAL.**—The Office of Indian Men’s Health shall be headed by a director, to be appointed by the Secretary.

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

(3) **REPORT.**—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, shall submit to Congress a report describing—

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

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

(b) **OFFICE OF INDIAN WOMEN’S HEALTH.**—The Secretary, acting through the Service, shall establish an office, to be known as the “Office of Indian Women’s Health”, to monitor and improve the quality of health care for Indian women (including urban Indian women) of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

[Section 224 repealed by section 101(b)(5) of S. 1790 (as reported by the Senate and enacted into law by section 10221(a) of Public Law 111–148; enactment date March 23, 2010.)]

LIMITATION ON USE OF FUNDS

SEC. 225. [25 U.S.C. 1621x] Amounts appropriated to carry out this title may not be used in a manner inconsistent with the Assisted Suicide Funding Restriction Act of 1997.

SEC. 226. [25 U.S.C. 1621y] **CONTRACT HEALTH SERVICE ADMINISTRATION AND DISBURSEMENT FORMULA.**

(a) **SUBMISSION OF REPORT.**—As soon as practicable after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General of the United States shall submit to the Secretary, the Committee on Indian Affairs of the Senate, and the Committee on Natural Resources of the House of Representatives, and make available to each Indian tribe, a report describing the results of the study of the Comptroller General regarding the funding of the contract health service program (including historic funding levels and a recommendation of the funding level needed for the program) and the administration of the contract health service program (including the distribution of funds pursuant to the program), as requested by Congress in March 2009, or pursuant to section 830.

(b) **CONSULTATION WITH TRIBES.**—On receipt of the report under subsection (a), the Secretary shall consult with Indian tribes regarding the contract health service program, including the distribution of funds pursuant to the program—

(1) to determine whether the current distribution formula would require modification if the contract health service program were funded at the level recommended by the Comptroller General;

(2) to identify any inequities in the current distribution formula under the current funding level or inequitable results for any Indian tribe under the funding level recommended by the Comptroller General;

(3) to identify any areas of program administration that may result in the inefficient or ineffective management of the program; and

(4) to identify any other issues and recommendations to improve the administration of the contract health services program and correct any unfair results or funding disparities identified under paragraph (2).

(c) **SUBSEQUENT ACTION BY SECRETARY.**—If, after consultation with Indian tribes under subsection (b), the Secretary determines that any issue described in subsection (b)(2) exists, the Secretary may initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate or promulgate regulations to establish a disbursement formula for the contract health service program funding.

TITLE III—HEALTH FACILITIES

CONSULTATION; CLOSURE OF FACILITIES; REPORTS

SEC. 301. [25 U.S.C. 1631] (a) 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), popularly known as the Snyder Act, the Secretary, acting through the Service, shall—

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

(2) ensure, whenever practicable, that such facility meets the standards of the Joint Commission on Accreditation of Health Care Organizations by not later than 1 year after the date on which the construction or renovation of such facility is completed.

(b)(1) Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility of the Service, or any portion of such a hospital or facility, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such hospital or facility (or portion thereof) is proposed to be closed 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) 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) HEALTH CARE FACILITY PRIORITY SYSTEM.—

(1) IN GENERAL.—

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

(i) shall be developed in consultation with Indian tribes and tribal organizations;

(ii) shall give Indian tribes' needs the highest priority;

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

(II) shall include the methodology required in paragraph (2)(B)(v); and

(III) may include such health care facilities, and such renovation or expansion needs of any health care facility, as the Service may identify; and

(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian tribes, and tribal organizations for consideration under the priority system at least once every 3 years, or more frequently as the Secretary determines to be appropriate.

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

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

(D) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall not be affected by any change in

the construction priority system taking place after that date if the project—

(i) was identified in the fiscal year 2008 Service budget justification as—

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

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

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

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

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

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

(I) on the initiative of the Secretary; or

(II) pursuant to a request of an Indian tribe or tribal organization.

(2) REPORT; CONTENTS.—

(A) INITIAL COMPREHENSIVE REPORT.—

(i) DEFINITIONS.—In this subparagraph:

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

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

(bb) to address other facilities issues.

(II) FACILITIES NEEDS ASSESSMENT WORKGROUP.—The term “Facilities Needs Assessment Workgroup” means the workgroup established at the discretion of the Director—

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

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

(ii) INITIAL REPORT.—

(I) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the comprehensive, national, ranked list of all health care facilities needs for the Service, Indian tribes, and tribal organizations (including inpatient health care facilities, outpatient health care facilities,

specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters, and the renovation and expansion needs, if any, of such facilities) developed by the Service, Indian tribes, and tribal organizations for the Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board.

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

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

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

(iii) UPDATES OF REPORT.—Beginning in calendar year 2011, the Secretary shall—

(I) update the report under clause (ii) not less frequently than once every 5 years; and

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

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

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

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

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

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

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

(IV) the 10 top-priority staff quarters developments associated with health care facilities.

(iii) The justification for such order of priority.

(iv) The projected cost of such projects.

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

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

(A) consult with and obtain information on all health care facilities needs from Indian tribes and tribal organizations; and

(B) review the total unmet needs of all Indian tribes and tribal organizations for health care facilities (including

staff quarters), including needs for renovation and expansion of existing facilities.

(d) REVIEW OF METHODOLOGY USED FOR HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM.—

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

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

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

(2) SUBMISSION TO CONGRESS.—The Comptroller General of the United States shall submit the report under paragraph (1) to—

(A) the Committees on Indian Affairs and Appropriations of the Senate;

(B) the Committees on Natural Resources and Appropriations of the House of Representatives; and

(C) the Secretary.

(e) FUNDING CONDITION.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the “Snyder Act”), for the planning, design, construction, or renovation of health facilities for the benefit of 1 or more Indian Tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f) or sections 504 and 505 of that Act (25 U.S.C. 458aaa–3, 458aaa–4).

(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes and tribal organizations, and confer with urban Indian organizations, in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, that may include—

(1) the establishment of an area distribution fund in which a portion of health facility construction funding could be devoted to all Service areas;

(2) approaches provided for in other provisions of this title; and

(3) other approaches, as the Secretary determines to be appropriate.

(g) PRIORITY OF CERTAIN PROJECTS PROTECTED.—The priority of any project established under the construction priority system in effect on the date of enactment of this Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall not be affected by any change in the construction priority system taking place after that date if the project—

(1) was identified in the fiscal year 2008 Service budget justification as—

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

- (B) 1 of the 10 top-priority outpatient projects;
- (C) 1 of the 10 top-priority staff quarters developments; or
- (D) 1 of the 10 top-priority Youth Regional Treatment Centers;
- (2) had completed both Phase I and Phase II of the construction priority system in effect on the date of enactment of such Act; or
- (3) is not included in clause (i) or (ii) and is selected, as determined by the Secretary—
 - (A) on the initiative of the Secretary; or
 - (B) pursuant to a request of an Indian tribe or tribal organization.
- (h) 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 Act.

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. [25 U.S.C. 1632] (a) The Congress hereby finds and declares that—

- (1) the provision of safe water supply systems and sanitary sewage and solid waste disposal systems 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 systems;
 - (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 systems and other preventive health measures;
 - (4) many Indian homes and communities still lack safe water supply systems and sanitary sewage and solid waste disposal systems; 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 systems and sanitary sewage waste disposal systems as soon as possible.
- (b)(1) 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, 1954¹³ (42 U.S.C. 2004a).
- (2) The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954¹³ (42 U.S.C. 2004a)—
- (A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of

¹³This Act is commonly referred to as the "Transfer Act", which is included in this compilation.

utility organizations to operate and maintain Indian sanitation facilities;

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

(C) operation and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities.

(3) Notwithstanding any other provision of law—

(A) the Secretary of Housing and Urban Affairs is authorized to transfer funds appropriated under the Housing and Community Development Act of 1974 (42 U.S.C. 5301, et seq.) to the Secretary of Health and Human Services, and

(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, 1954¹³ (42 U.S.C. 2004a).

(c) Beginning in fiscal year 1990, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitation sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

(d) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

(e)(1) The Secretary is authorized to provide financial assistance to Indian tribes and communities in an amount equal to the Federal share of the costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (c).

(2) For the purposes of paragraph (1), the term “Federal share” means 80 percent of the costs described in paragraph (1).

(3) With respect to Indian tribes with fewer than 1,000 enrolled members, the non-Federal portion of the costs of operating, managing, and maintaining such facilities may be provided, in part, through cash donations or in kind property, fairly evaluated.

(f) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination 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 or sewage disposal services, on an equal basis with programs that are administered directly by the Service.

(g)(1) 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 sanitation deficiency for each sanitation facilities project of each Indian tribe or community;

(D) the amount of funds necessary to raise all Indian tribes and communities to a level I sanitation deficiency; and

(E) the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency.

(2) 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 care programs or facilities under any contract entered into with the Service under the Indian Self-Determination Act) to determine the sanitation needs of each tribe.

(3) The methodology used by the Secretary in determining sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

(4) For purposes of this subsection, the sanitation deficiency levels for an Indian tribe or community are as follows:

(A) level I is an Indian tribe or community with a sanitation system—

(i) which complies with all applicable water supply and pollution control laws, and

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

(B) level II is an Indian tribe or community with a sanitation system—

(i) which complies with all applicable water supply and pollution control laws, and

(ii) in which the deficiencies relate to capital improvements that are necessary to improve the facilities in order to meet the needs of such tribe or community for domestic sanitation facilities;

(C) level III is an Indian tribe or community with a sanitation system which—

(i) has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or

(ii) has no solid waste disposal facility;

(D) level IV is an Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

(E) level V is an Indian tribe or community that lacks a safe water supply and a sewage disposal system.

(5) For purposes of this subsection, any Indian tribe or community that lacks the operation and maintenance capability to enable its sanitation system to meet pollution control laws may not be treated as having a level I or II sanitation deficiency.

PREFERENCE TO INDIANS AND INDIAN FIRMS

SEC. 303. [25 U.S.C. 1633] (a) The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910¹⁴ (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

¹⁴This Act is commonly referred to as the "Buy Indian Act", which is included in this compilation.

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 he finds, pursuant to rules and regulations promulgated by him, 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 his finding, shall consider whether the Indian or Indian firm will be deficient with respect to (1) ownership and control by Indians, (2) equipment, (3) book-keeping and accounting procedures, (4) substantive knowledge of the project or function to be contracted for, (5) adequately trained personnel, or (6) other necessary components of contract performance.

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

SOBOBA SANITATION FACILITIES

SEC. 304. * * * 15

EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION

SEC. 305. [25 U.S.C. 1634] (a)(1) Notwithstanding any other provision of law, the Secretary is authorized to accept any major renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination Act, including—

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

(B) any 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) The Secretary shall maintain a separate priority list to address the needs of such facilities for personnel or equipment.

(3) 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) The requirements of this subsection are met with respect to any renovation or modernization if—

(1) the tribe or tribal organization—

¹⁵The text of this section is amendatory and currently reads as follows: “The Act of December 17, 1970 (84 Stat. 1465), is hereby amended by adding the following new section 9 at the end thereof:

“SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat 674), as amended by the Act of July 31, 1959 (73 Stat. 267).”

- (A) provides notice to the Secretary of its intent to 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 personnel or equipment; and
- (2) the renovation or modernization—
 - (A) is approved by the appropriate area director of the Service; and
 - (B) is administered by the tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.
- (c) If any Service facility which has been 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 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 renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such renovation or modernization) bore to the value of such facility at the time of the completion of such renovation or modernization.

GRANT PROGRAM FOR THE CONSTRUCTION, EXPANSION, AND
MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES

SEC. 306. [25 U.S.C. 1636] (a)(1) The Secretary, acting through the Service, shall make grants to tribes and tribal organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided in subsection (c)(1)(C)). A grant made under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term “construction” includes the replacement of an existing facility.

(2) A grant under paragraph (1) may only be made to a 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 a tribe or tribal organization) pursuant to a contract entered into under the Indian Self-Determination Act.

(b)(1) A grant 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) serve no less than 500 eligible Indians annually;
- and

(iii) provide ambulatory care in a service area (specified in the contract entered into under the Indian Self-Determination Act) with a population of not less than 2,000 eligible Indians.

(2) The requirements of clauses (ii) and (iii) of paragraph (1)(C) shall not apply to a tribe or tribal organization applying for a grant under this section whose tribal government offices are located on an island.

(c)(1) No grant may be made under this section unless an application for such a grant has been submitted to and approved by the Secretary. An application for a grant under this section shall be submitted in such form and manner as the Secretary shall by regulation prescribe 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 a grant received under this section—

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

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

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

(2) In awarding grants 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) If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, at any time after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing ambulatory 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.

SEC. 307. [25 U.S.C. 1637] INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

(a) PURPOSE AND GENERAL AUTHORITY.—

(1) PURPOSE.—The purpose of this section is to encourage the establishment of demonstration projects that meet the applicable criteria of this section to be carried out by the Secretary, acting through the Service, or Indian tribes or tribal organizations acting pursuant to contracts or compacts under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

(A) to test alternative means of delivering health care and services to Indians through facilities; or

(B) to use alternative or innovative methods or models of delivering health care services to Indians (including primary care services, contract health services, or any other program or service authorized by this Act) through convenient care services (as defined in subsection (c)), community health centers, or cooperative agreements or arrangements with other health care providers that share or coordinate the use of facilities, funding, or other resources, or other-

wise coordinate or improve the coordination of activities of the Service, Indian tribes, or tribal organizations, with those of the other health care providers.

(2) **AUTHORITY.**—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations to carry out, health care delivery demonstration projects that—

(A) test alternative means of delivering health care and services to Indians through facilities; or

(B) otherwise carry out the purposes of this section.

(b) **USE OF FUNDS.**—The Secretary, in approving projects pursuant to this section—

(1) may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services; and

(2) is authorized—

(A) to waive any leasing prohibition;

(B) to permit use and carryover of funds appropriated for the provision of health care services under this Act (including for the purchase of health benefits coverage, as authorized by section 402(a));

(C) to permit the use of other available funds, including other Federal funds, funds from third-party collections in accordance with sections 206, 207, and 401, and non-Federal funds contributed by State or local governmental agencies or facilities or private health care providers pursuant to cooperative or other agreements with the Service, 1 or more Indian tribes, or tribal organizations;

(D) to permit the use of funds or property donated or otherwise provided from any source for project purposes;

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

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

(c) **HEALTH CARE DEMONSTRATION PROJECTS.**—

(1) **DEFINITION OF CONVENIENT CARE SERVICE.**—In this subsection, the term “convenient care service” means any primary health care service, such as urgent care services, non-emergent care services, prevention services and screenings, and any service authorized by section 203 or 205(d), that is offered—

(A) at an alternative setting; or

(B) during hours other than regular working hours.

(2) **GENERAL PROJECTS.**—

(A) **CRITERIA.**—The Secretary may approve under this section demonstration projects that meet the following criteria:

(i) There is a need for a new facility or program, such as a program for convenient care services, or an improvement in, increased efficiency at, or reorientation of an existing facility or program.

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

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

(iv) The project is economically viable.

(v) For projects carried out by an Indian tribe or tribal organization, the Indian tribe or tribal organization has the administrative and financial capability to administer the project.

(vi) The project is integrated with providers of related health or social services (including State and local health care agencies or other health care providers) and is coordinated with, and avoids duplication of, existing services in order to expand the availability of services.

(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service units:

(i) Cass Lake, Minnesota.

(ii) Mescalero, New Mexico.

(iii) Owyhee and Elko, Nevada.

(iv) Schurz, Nevada.

(v) Ft. Yuma, California.

(3) INNOVATIVE HEALTH SERVICES DELIVERY DEMONSTRATION PROJECT.—

(A) APPLICATION OR REQUEST.—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization within a Service area, the Secretary shall take into consideration alternative or innovated methods to deliver health care services within the Service area (or a portion of, or facility within, the Service area) as described in the application or request, including medical, dental, pharmaceutical, nursing, clinical laboratory, contract health services, convenient care services, community health centers, or any other health care services delivery models designed to improve access to, or efficiency or quality of, the health care, health promotion, or disease prevention services and programs under this Act.

(B) APPROVAL.—In addition to projects described in paragraph (2), in any fiscal year, the Secretary is authorized under this paragraph to approve not more than 10 applications for health care delivery demonstration projects that meet the criteria described in subparagraph (C).

(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

(i) The criteria set forth in paragraph (2)(A).

(ii) There is a lack of access to health care services at existing health care facilities, which may be due to

limited hours of operation at those facilities or other factors.

(iii) The project—

(I) expands the availability of services; or

(II) reduces—

(aa) the burden on Contract Health Services; or

(bb) the need for emergency room visits.

(d) **TECHNICAL ASSISTANCE.**—On receipt of an application or request from an Indian tribe, a consortium of Indian tribes, or a tribal organization, the Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section, including information regarding the Service unit budget and available funding for carrying out the proposed demonstration project.

(e) **SERVICE TO INELIGIBLE PERSONS.**—Subject to section 813, the authority to provide services to persons otherwise ineligible for the health care benefits of the Service, and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 813, may be included, subject to the terms of that section, in any demonstration project approved pursuant to this section.

(f) **EQUITABLE TREATMENT.**—For purposes of subsection (c), the Secretary, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), shall 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 that are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

LAND TRANSFER

SEC. 308. [25 U.S.C. 1638] 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. [25 U.S.C. 1638a] TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

(a) **RENTAL RATES.**—

(1) **ESTABLISHMENT.**—Notwithstanding any other provision of law, a tribal health program that operates a hospital or other health facility and the federally owned quarters associated with such a facility pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may establish the rental rates

charged to the occupants of those quarters, on providing notice to the Secretary.

(2) OBJECTIVES.—In establishing rental rates under this subsection, a tribal health program shall attempt—

(A) to base the rental rates on the reasonable value of the quarters to the occupants of the quarters; and

(B) to generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and at the discretion of the tribal health program, to supply reserve funds for capital repairs and replacement of the quarters.

(3) EQUITABLE FUNDING.—A federally owned quarters the rental rates for which are established by a tribal health program under this subsection shall remain eligible to receive improvement and repair funds to the same extent that all federally owned quarters used to house personnel in programs of the Service are eligible to receive those funds.

(4) NOTICE OF RATE CHANGE.—A tribal health program that establishes a rental rate under this subsection shall provide occupants of the federally owned quarters a notice of any change in the rental rate by not later than the date that is 60 days notice before the effective date of the change.

(5) RATES IN ALASKA.—A rental rate established by a tribal health program under this section for a federally owned quarters in the State of Alaska 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.

(b) DIRECT COLLECTION OF RENT.—

(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), a tribal health program may collect rent directly from Federal employees who occupy federally owned quarters if the tribal health program submits to the Secretary and the employees a notice of the election of the tribal health program to collect rents directly from the employees.

(2) ACTION BY EMPLOYEES.—On receipt of a notice described in paragraph (1)—

(A) the affected Federal employees shall pay rent for occupancy of a federally owned quarters directly to the applicable tribal health program; and

(B) the Secretary shall not have the authority to collect rent from the employees through payroll deduction or otherwise.

(3) USE OF PAYMENTS.—The rent payments under this subsection—

(A) shall be retained by the applicable tribal health program in a separate account, which shall be used by the tribal health program for the maintenance (including capital repairs and replacement) and operation of the quarters, as the tribal health program determines to be appropriate; and

(B) shall not be made payable to, or otherwise be deposited with, the United States.

(4) **RETROCESSION OF AUTHORITY.**—If a tribal health program that elected to collect rent directly under paragraph (1) requests retrocession of the authority of the tribal health program to collect that rent, the retrocession shall take effect on the earlier of—

(A) the first day of the month that begins not less than 180 days after the tribal health program submits the request; and

(B) such other date as may be mutually agreed on by the Secretary and the tribal health program.

APPLICABILITY OF BUY AMERICAN REQUIREMENT

SEC. 310. [25 U.S.C. 1638b] (a) The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds made available to carry out this title.

(b) The Secretary shall submit to the Congress a report on the amount of procurements from foreign entities made in fiscal years 1993 and 1994 with funds made available to carry out this title. Such report shall separately indicate the dollar value of items procured with such funds for which the Buy American Act was waived pursuant to the Trade Agreement Act of 1979¹⁶ or any international agreement to which the United States is a party.

(c) 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 made available to carry out this title, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(d) For purposes of this section, the term “Buy American Act” means title III of the Act entitled “An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes”, approved March 3, 1933 (41 U.S.C. 10a et seq.).

SEC. 311. [25 U.S.C. 1638e] OTHER FUNDING, EQUIPMENT, AND SUPPLIES FOR FACILITIES.

(a) **AUTHORIZATION.**—

(1) **AUTHORITY TO TRANSFER FUNDS.**—The head of any Federal agency to which funds, equipment, or other supplies are made available for the planning, design, construction, or operation of a health care or sanitation facility may transfer the funds, equipment, or supplies to the Secretary for the planning, design, construction, or operation of a health care or sanitation facility to achieve—

(A) the purposes of this Act; and

(B) the purposes for which the funds, equipment, or supplies were made available to the Federal agency.

(2) **AUTHORITY TO ACCEPT FUNDS.**—The Secretary may—

¹⁶So in original. Should probably be “Trade Agreements Act of 1979”.

(A) accept from any source, including Federal and State agencies, funds, equipment, or supplies that are available for the construction or operation of health care or sanitation facilities; and

(B) use those funds, equipment, and supplies to plan, design,¹⁷ construct, and operate health care or sanitation facilities for Indians, including pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(3) EFFECT OF RECEIPT.—Receipt of funds by the Secretary under this subsection shall not affect any priority established under section 301.

(b) INTERAGENCY AGREEMENTS.—The Secretary may enter into interagency agreements with Federal or State agencies and other entities, and accept funds, equipment, or other supplies from those entities, to provide for the planning, design, construction, and operation of health care or sanitation facilities to be administered by Indian health programs to achieve—

(1) the purposes of this Act; and

(2) the purposes for which the funds were appropriated or otherwise provided.

(c) ESTABLISHMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary, acting through the Service, shall establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians under this Act.

(2) OTHER REGULATIONS.—Notwithstanding any other provision of law, any other applicable regulations of the Department shall apply in carrying out projects using funds transferred under this section.

(d) DEFINITION OF SANITATION FACILITY.—In this section, the term “sanitation facility” means a safe and adequate water supply system, sanitary sewage disposal system, or sanitary solid waste system (including all related equipment and support infrastructure).

SEC. 312. [25 U.S.C. 1638f] INDIAN COUNTRY MODULAR COMPONENT FACILITIES DEMONSTRATION PROGRAM.

(a) DEFINITION OF MODULAR COMPONENT HEALTH CARE FACILITY.—In this section, the term “modular component health care facility” means a health care facility that is constructed—

(1) off-site using prefabricated component units for subsequent transport to the destination location; and

(2) represents a more economical method for provision of health care facility than a traditionally constructed health care building.

(b) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall award no less than 3 grants for purchase, installation and maintenance of modular component health care facilities in Indian communities for provision of health care services.

(c) SELECTION OF LOCATIONS.—

(1) PETITIONS.—

¹⁷ So in law.

(A) SOLICITATION.—The Secretary shall solicit from Indian tribes petitions for location of the modular component health care facilities in the Service areas of the petitioning Indian tribes.

(B) PETITION.—To be eligible to receive a grant under this section, an Indian tribe or tribal organization must submit to the Secretary a petition to construct a modular component health care facility in the Indian community of the Indian tribe, at such time, in such manner, and containing such information as the Secretary may require.

(2) SELECTION.—In selecting the location of each modular component health care facility to be provided under the demonstration program, the Secretary shall give priority to projects already on the Indian Health Service facilities construction priority list and petitions which demonstrate that erection of a modular component health facility—

(A) is more economical than construction of a traditionally constructed health care facility;

(B) can be constructed and erected on the selected location in less time than traditional construction; and

(C) can adequately house the health care services needed by the Indian population to be served.

(3) EFFECT OF SELECTION.—A modular component health care facility project selected for participation in the demonstration program shall not be eligible for entry on the facilities construction priorities list entitled “IHS Health Care Facilities FY 2011 Planned Construction Budget” and dated May 7, 2009 (or any successor list).

(d) ELIGIBILITY.—

(1) IN GENERAL.—An Indian tribe may submit a petition under subsection (c)(1)(B) regardless of whether the Indian tribe is a party to any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(2) ADMINISTRATION.—At the election of an Indian tribe or tribal organization selected for participation in the demonstration program, the funds provided for the project shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

(e) REPORTS.—Not later than 1 year after the date on which funds are made available for the demonstration program and annually thereafter, the Secretary shall submit to Congress a report describing—

(1) each activity carried out under the demonstration program, including an evaluation of the success of the activity; and

(2) the potential benefits of increased use of modular component health care facilities in other Indian communities.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$50,000,000 to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be necessary to carry out the program in subsequent fiscal years.

SEC. 313. [25 U.S.C. 1638g] MOBILE HEALTH STATIONS DEMONSTRATION PROGRAM.

(a) **DEFINITIONS.**—In this section:

(1) **ELIGIBLE TRIBAL CONSORTIUM.**—The term “eligible tribal consortium” means a consortium composed of 2 or more Service units between which a mobile health station can be transported by road in up to 8 hours. A Service unit operated by the Service or by an Indian tribe or tribal organization shall be equally eligible for participation in such consortium.

(2) **MOBILE HEALTH STATION.**—The term “mobile health station” means a health care unit that—

(A) is constructed, maintained, and capable of being transported within a semi-trailer truck or similar vehicle;

(B) is equipped for the provision of 1 or more specialty health care services; and

(C) can be equipped to be docked to a stationary health care facility when appropriate.

(3) **SPECIALTY HEALTH CARE SERVICE.**—

(A) **IN GENERAL.**—The term “specialty health care service” means a health care service which requires the services of a health care professional with specialized knowledge or experience.

(B) **INCLUSIONS.**—The term “specialty health care service” includes any service relating to—

(i) dialysis;

(ii) surgery;

(iii) mammography;

(iv) dentistry; or

(v) any other specialty health care service.

(b) **ESTABLISHMENT.**—The Secretary, acting through the Service, shall establish a demonstration program under which the Secretary shall provide at least 3 mobile health station projects.

(c) **PETITION.**—To be eligible to receive a mobile health station under the demonstration program, an eligible tribal consortium shall submit to the Secretary, a petition at such time, in such manner, and containing—

(1) a description of the Indian population to be served;

(2) a description of the specialty service or services for which the mobile health station is requested and the extent to which such service or services are currently available to the Indian population to be served; and

(3) such other information as the Secretary may require.

(d) **USE OF FUNDS.**—The Secretary shall use amounts made available to carry out the demonstration program under this section—

(1)(A) to establish, purchase, lease, or maintain mobile health stations for the eligible tribal consortia selected for projects; and

(B) to provide, through the mobile health station, such specialty health care services as the affected eligible tribal consortium determines to be necessary for the Indian population served;

(2) to employ an existing mobile health station (regardless of whether the mobile health station is owned or rented and

operated by the Service) to provide specialty health care services to an eligible tribal consortium; and

(3) to establish, purchase, or maintain docking equipment for a mobile health station, including the establishment or maintenance of such equipment at a modular component health care facility (as defined in section 312(a)), if applicable.

(e) REPORTS.—Not later than 1 year after the date on which the demonstration program is established under subsection (b) and annually thereafter, the Secretary, acting through the Service, shall submit to Congress a report describing—

(1) each activity carried out under the demonstration program including an evaluation of the success of the activity; and

(2) the potential benefits of increased use of mobile health stations to provide specialty health care services for Indian communities.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$5,000,000 per year to carry out the demonstration program under this section for the first 5 fiscal years, and such sums as may be needed to carry out the program in subsequent fiscal years.

TITLE IV—ACCESS TO HEALTH SERVICES

SEC. 401. [25 U.S.C. 1641] TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

(a) DISREGARD OF MEDICARE, MEDICAID, AND CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—Any payments received by an Indian health program or by an urban Indian organization under title XVIII, XIX, or XXI of the Social Security Act for services provided to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

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

(c) USE OF FUNDS.—

(1) SPECIAL FUND.—

(A) 100 PERCENT PASS-THROUGH OF PAYMENTS DUE TO FACILITIES.—Notwithstanding any other provision of law, but subject to paragraph (2), payments to which a facility of the Service is entitled by reason of a provision of title XVIII or XIX of the Social Security Act shall be placed in a special fund to be held by the Secretary. In making payments from such fund, the Secretary shall ensure that each Service unit of the Service receives 100 percent of the amount to which the facilities of the Service, for which such Service unit makes collections, are entitled by reason of a provision of either such title.

(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) by reason of a provision of title XVIII or XIX of the Social Security Act shall first be used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service operated by

or through such facility which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such respective title. Any amounts so received that are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to consultation with the Indian tribes being served by the Service unit, be used for reducing the health resource deficiencies (as determined in section 201(c)) of such Indian tribes, including the provision of services pursuant to section 205.

(2) DIRECT PAYMENT OPTION.—Paragraph (1) shall not apply to a tribal health program upon the election of such program under subsection (d) to receive payments directly. No payment may be made out of the special fund described in such paragraph with respect to reimbursement made for services provided by such program during the period of such election.

(d) DIRECT BILLING.—

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

(2) DIRECT REIMBURSEMENT.—

(A) USE OF FUNDS.—Each tribal health program making the election described in paragraph (1) with respect to a program under a title of the Social Security Act shall be reimbursed directly by that program for items and services furnished without regard to subsection (c)(1), except that all amounts so reimbursed shall be used by the tribal health program for the purpose of making any improvements in facilities of the tribal health program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and tribal health programs, any health care-related purpose (including coverage for a service or service within a contract health service delivery area or any portion of a contract health service delivery area that would otherwise be provided as a contract health service), or otherwise to achieve the objectives provided in section 3 of this Act.

(B) AUDITS.—The amounts paid to a tribal health program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to the program under such title, as well as all auditing requirements applicable to programs administered by an Indian health program. Nothing in the preceding sentence shall be construed as limiting the application of auditing requirements applicable to amounts paid under title XVIII, XIX, or XXI of the Social Security Act.

(C) IDENTIFICATION OF SOURCE OF PAYMENTS.—Any tribal health program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such program receives such reimbursements or payments.

(3) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

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

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

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

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

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

SEC. 402. [25 U.S.C. 1642] PURCHASING HEALTH CARE COVERAGE.

(a) IN GENERAL.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian

Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 404) to Indian tribes, tribal organizations, and urban Indian organizations for health benefits for Service beneficiaries, Indian tribes, tribal organizations, and urban Indian organizations may use such amounts to purchase health benefits coverage (including coverage for a service, or service within a contract health service delivery area, or any portion of a contract health service delivery area that would otherwise be provided as a contract health service) for such beneficiaries in any manner, including through—

- (1) a tribally owned and operated health care plan;
- (2) a State or locally authorized or licensed health care plan;
- (3) a health insurance provider or managed care organization;
- (4) a self-insured plan; or
- (5) a high deductible or health savings account plan.

(b) **FINANCIAL NEED.**—The purchase of coverage under subsection (a) by an Indian tribe, tribal organization, or urban Indian organization may be based on the financial needs of such beneficiaries (as determined by the 1 or more Indian tribes being served based on a schedule of income levels developed or implemented by such 1 or more Indian tribes).

(c) **EXPENSES FOR SELF-INSURED PLAN.**—In the case of a self-insured plan under subsection (a)(4), the amounts may be used for expenses of operating the plan, including administration and insurance to limit the financial risks to the entity offering the plan.

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

REPORT

SEC. 403. [25 U.S.C. 1643] 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 through title XVIII and XIX of the Social Security Act, as amended.

SEC. 404. [25 U.S.C. 1644] GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS TO FACILITATE OUTREACH, ENROLLMENT, AND COVERAGE OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS AND OTHER HEALTH BENEFITS PROGRAMS.

(a) **INDIAN TRIBES AND TRIBAL ORGANIZATIONS.**—The Secretary, acting through the Service, shall make grants to or enter into contracts with Indian tribes and tribal organizations to assist such tribes and tribal organizations in establishing and administering programs on or near reservations and trust lands, including programs to provide outreach and enrollment through video, electronic delivery methods, or telecommunication devices that allow real-time or time-delayed communication between individual Indians and the benefit program, to assist individual Indians—

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

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

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

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

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

(3) to provide transportation for such individual Indians to the appropriate offices for enrollment or applications for such benefits; and

(4) to develop and implement methods of improving the participation of Indians in receiving benefits under such programs.

(c) APPLICATION TO URBAN INDIAN ORGANIZATIONS.—

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

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

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

(B) appropriate to urban Indian organizations and urban Indians; and

(C) necessary to effect the purposes of this section.

(d) FACILITATING COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall develop and disseminate best practices that will serve to facilitate cooperation with, and agreements between, States and the Service, Indian tribes, tribal organizations, or urban Indian organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI of the Social Security Act.

(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements of the Secretary, acting through the Service, for the collection, preparation, and submission of applications by Indians for assistance under the Med-

icaid and children's health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program established under title XVIII of such Act, see subsections (a) and (b) of section 1139 of the Social Security Act.

(f) DEFINITION OF PREMIUMS AND COST SHARING.—In this section:

(1) PREMIUM.—The term “premium” includes any enrollment fee or similar charge.

(2) COST SHARING.—The term “cost sharing” includes any deduction, deductible, copayment, coinsurance, or similar charge.

SEC. 405. [25 U.S.C. 1645] SHARING ARRANGEMENTS WITH FEDERAL AGENCIES.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary may enter into (or expand) arrangements for the sharing of medical facilities and services between the Service, Indian tribes, urban Indian organizations, and tribal organizations and the Department of Veterans Affairs and the Department of Defense.

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

(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

(1) the priority access of any Indian to health care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

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

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

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

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

(c) REIMBURSEMENT.—The Service, Indian tribe, urban Indian organization, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, an urban Indian organization, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law, regardless of whether such services are provided directly by the Service, an Indian tribe, or tribal organization, through purchased/referred care, or through a contract for travel described in section 213(b).

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

AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES

SEC. 406. [25 U.S.C. 1646] With respect to an elderly or disabled Indian 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. 407. [25 U.S.C. 1647] ELIGIBLE INDIAN VETERAN SERVICES.

(a) FINDINGS; PURPOSE.—

(1) FINDINGS.—Congress finds that—

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

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

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

(b) DEFINITIONS.—In this section:

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

(A) authorized under the laws administered by the Secretary of Veterans Affairs; and

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

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

(c) ELIGIBLE INDIAN VETERANS EXPENSES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B).

(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Secretary determines to be appropriate

regarding the method of payments to the Secretary of Veterans Affairs under paragraph (1).

(d) **TRIBAL APPROVAL OF MEMORANDA.**—In negotiating a local memorandum of understanding with the Secretary of Veterans Affairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of understanding.

(e) **FUNDING.**—

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

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

SEC. 408. [25 U.S.C. 1647a] NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

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

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

(2) **SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.**—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

(b) **APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.**—

(1) **EXCLUDED ENTITIES.**—No entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement

under any such program for health care services furnished to an Indian.

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

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

(c) **RELATED PROVISIONS.**—For provisions related to non-discrimination against providers operated by the Service, an Indian tribe, tribal organization, or urban Indian organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).

SEC. 409. [25 U.S.C. 1647b] 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 (25 U.S.C. 5301 et seq.) or the Tribally Controlled Schools Act of 1988 (25 U.S.C. 2501 et seq.) 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. 410. [25 U.S.C. 1647c] GENERAL EXCEPTIONS.

The requirements of this title shall not apply to any excepted benefits described in paragraph (1)(A) or (3) of section 2791(c) of the Public Health Service Act (42 U.S.C. 300gg–91).

SEC. 411. [25 U.S.C. 1647d] NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY.

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

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

(1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of

the Social Security Act, to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;

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

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

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

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

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

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

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

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

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

SEC. 501. [25 U.S.C. 1651] The purpose of this title is to establish programs in urban centers to make health services more accessible to urban Indians.

SEC. 502. [25 U.S.C. 1652] CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—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 enter into contracts with, or make grants to, urban Indian organizations to assist the urban Indian organizations in the establishment and administration, within urban centers, of programs that meet the requirements of this title.

(b) CONDITIONS.—Subject to section 506, the Secretary, acting through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract into which the Secretary enters with, or in any grant the Sec-

retary makes to, any urban Indian organization pursuant to this title.

CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND
REFERRAL SERVICES

SEC. 503. [25 U.S.C. 1653] (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians residing in the urban centers in which such organizations are situated. 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 in which such organization is situated 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;

(3) estimate the current health care needs of urban Indians residing in such urban center;

(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

(5) determine the use of public and health services resources by the urban Indians residing in such urban center;

(6) assist such health services resources in providing services to urban Indians;

(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

(8) provide basic health education, including health promotion and disease prevention education, to urban Indians;

(9) establish and implement training programs to accomplish the referral and education tasks set forth in paragraphs (6) through (8) of this subsection;

(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

(11) 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

(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

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

(1) the extent of unmet health care needs of urban Indians in the urban center involved;

(2) the size of the urban Indian population in the urban center involved;

(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

(B) any project funded under this title;

(5) 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;

(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

(8) 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) 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)(1) 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 pursuant to this section or receiving grants under subsection (a).

(2) In making any grant to carry out this subsection, the Secretary shall take into consideration—

(A) the size of the urban Indian population to be served;

(B) the immunization levels of the urban Indian population, particularly the immunization levels of infants, children, and the elderly;

(C) the utilization by the urban Indians of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population; and

(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.

(3) For purposes of this subsection, the term “immunization services” means services to provide without charge immunizations against vaccine-preventable diseases.

(e)(1) 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 pursuant to this section or receiving grants under subsection (a).

(2) 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 bar-

riers to obtaining those services and resources, and the needs that are unmet by such services and resources.

(3) 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 mental health services, to educate urban Indians about mental health issues and services, and effect coordination with existing mental health providers in order to improve services to urban Indians;

(C) to provide outpatient mental 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 mental health service delivery models which incorporate Indian cultural support systems and resources.

(f)(1) 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) 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) 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) 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).

CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET
HEALTH CARE NEEDS

SEC. 504. [25 U.S.C. 1654] (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, 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. 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) 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 clauses (2), (3), (4), and (8) of section 503(b); and

(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within one year after the date on which the Secretary and such organization enter into such contract, or within one year after such organization receives such grant, whichever is applicable.

(c) The Secretary may not renew any contract entered into, or grant made, under this section.

EVALUATIONS; RENEWALS

SEC. 505. [25 U.S.C. 1655] (a) The Secretary, 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) The Secretary, through the Service, shall conduct an annual onsite evaluation of each urban Indian organization which has entered into a contract or received a grant under section 503 for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract or the terms of such grant.

(c) 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 un-

satisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such 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) 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 conducted under subsection (b).

OTHER CONTRACT AND GRANT REQUIREMENTS

SEC. 506. [25 U.S.C. 1656] (a) Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations 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 under any contracts or grants pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) 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) In connection with any contract or grant entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract or grant, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

(e) 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.

(f) Urban Indians, as defined in section 4(f) of this Act, shall be eligible for health care or referral services provided pursuant to this title.

REPORTS AND RECORDS

SEC. 507. [25 U.S.C. 1657] (a) For each fiscal year during which an urban Indian organization receives or expends funds pur-

suant to a contract entered into, or a grant received, pursuant to this title, such organization shall submit to the Secretary a quarterly report including—

(1) in the case of a contract or grant under section 503, information gathered pursuant to clauses (10) and (11) 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) such other information as the Secretary may request.

(b) 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) The Secretary shall allow as a cost of any contract or grant entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.

(d)(1) The Secretary, acting through the Service, shall submit a report to the Congress not later than March 31, 1992, evaluating—

(A) the health status of urban Indians;

(B) the services provided to Indians through this title;

(C) areas of unmet needs in urban areas served under this title; and

(D) areas of unmet needs in urban areas not served under this title.

(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

(3) The Secretary and the Secretary of the Interior shall—

(A) assess the status of the welfare of urban Indian children, including the volume of child protection cases, the prevalence of child sexual abuse, and the extent of urban Indian coordination with tribal authorities with respect to child sexual abuse; and

(B) submit a report on the assessment required under subparagraph (A), together with recommended legislation to improve Indian child protection in urban Indian populations, to the Congress no later than March 31, 1992.

LIMITATION ON CONTRACT AUTHORITY

SEC. 508. [25 U.S.C. 1658] The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

FACILITIES RENOVATION

SEC. 509. [25 U.S.C. 1659] The Secretary may make funds available to contractors or grant recipients under this title for renovations to facilities or construction or expansion of facilities, including leased facilities.

URBAN HEALTH PROGRAMS BRANCH

SEC. 510. [25 U.S.C. 1660] (a) ESTABLISHMENT.—There is hereby established within the Service a Branch of Urban Health Programs which shall be responsible for carrying out the provisions of this title and for providing central oversight of the programs and services authorized under this title.

(b) STAFF, SERVICES, AND EQUIPMENT.—The Secretary shall appoint such employees to work in the branch, including a program director, and shall provide such services and equipment, as may be necessary for it to carry out its responsibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request.

GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES

SEC. 511. [25 U.S.C. 1660a] (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) accessibility to, and utilization of, other health resources available to such population;
- (3) duplication of existing Service or other Federal grants or contracts;
- (4) capability of the organization to adequately perform the activities required under the grant;
- (5) 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
- (6) identification of need for services.

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. [25 U.S.C. 1660b] TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall—

(1) be permanent programs within the Service's direct care program;

(2) continue to be treated as Service units and operating units in the allocation of resources and coordination of care; and

(3) continue to meet the requirements and definitions of an urban Indian organization in this Act, and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

URBAN NIAAA TRANSFERRED PROGRAMS

SEC. 513. [25 U.S.C. 1660c] (a) The Secretary shall, within the Branch of Urban Health Programs of the Service, make grants or enter into contracts for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (hereafter in this section referred to as "NIAAA") and transferred to the Service.

(b) 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) 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) For the purpose of carrying out this section, the Secretary may combine NIAAA alcohol funds with other substance abuse funds currently administered through the Branch of Urban Health Programs of the Service.

(e) 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. [25 U.S.C. 1660d] CONFERRING WITH URBAN INDIAN ORGANIZATIONS.

(a) **DEFINITION OF CONFER.**—In this section, the term "confer" means to engage in an open and free exchange of information and opinions that—

(1) leads to mutual understanding and comprehension; and

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

(b) **REQUIREMENT.**—The Secretary shall ensure that the Service confers, to the maximum extent practicable, with urban Indian organizations in carrying out this Act.

SEC. 515. [25 U.S.C. 1660e] EXPANDED PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.

Notwithstanding any other provision of this Act, the Secretary, acting through the Service, is authorized to establish programs, including programs for awarding grants, for urban Indian organizations that are identical to any programs established pursuant to sections 218, 702, and 708(g).

SEC. 516. [25 U.S.C. 1660f] COMMUNITY HEALTH REPRESENTATIVES.

The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the

employment of Indians trained as health service providers through the Community Health Representative Program under section 107 in the provision of health care, health promotion, and disease prevention services to urban Indians.

SEC. 517. [25 U.S.C. 1660g] USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

(a) **IN GENERAL.**—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out the contract or grant, to use, in accordance with such terms and conditions for use and maintenance as are agreed on by the Secretary and the urban Indian organizations—

(1) any existing facility under the jurisdiction of the Secretary;

(2) all equipment contained in or pertaining to such an existing facility; and

(3) any other personal property of the Federal Government under the jurisdiction of the Secretary.

(b) **DONATIONS.**—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for the purposes of carrying out the contract or grant.

(c) **ACQUISITION OF PROPERTY.**—The Secretary may acquire excess or surplus personal or real property of the Federal Government 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 purposes of the contract or grant.

(d) **PRIORITY.**—If the Secretary receives from an urban Indian organization or an Indian tribe or tribal organization a request for a specific item of personal or real property described in subsection (b) or (c), 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 earlier of—

(1) the date on which the Secretary transfers title to the property to the urban Indian organization; and

(2) the date on which the Secretary transfers the property physically to the urban Indian organization.

(e) **EXECUTIVE AGENCY STATUS.**—For purposes of section 501(a) of title 40, United States Code, an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be considered to be an Executive agency in carrying out the contract or grant.

SEC. 518. [25 U.S.C. 1660h] HEALTH INFORMATION TECHNOLOGY.

The Secretary, acting through the Service, may make grants to urban Indian organizations under this title for the development, adoption, and implementation of health information technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C.

300jj)), telemedicine services development, and related infrastructure.

SEC. 519. [25 U.S.C. 1660i] DEEMING AN URBAN INDIAN ORGANIZATION AND EMPLOYEES THEREOF TO BE A PART OF THE PUBLIC HEALTH SERVICE FOR THE PURPOSES OF CERTAIN CLAIMS FOR PERSONAL INJURY.

Section 102(d) of the Indian Self-Determination and Education Assistance Act shall apply—

(1) to an Urban Indian organization to the same extent and in the same manner as such section applies to an Indian tribe, a tribal organization, and an Indian contractor; and

(2) to the employees of an Urban Indian organization to the same extent and in the same manner as such section applies to employees of an Indian tribe, a tribal organization, or an Indian contractor.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

SEC. 601. [25 U.S.C. 1661] 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) DIRECTOR.—The Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 2008, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.

(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day before the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 shall serve as Director.

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

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

(B) promote consultation on matters relating to Indian health.

(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

(c) DUTIES.—The Director shall—

(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, carried out by or

under the direction of the individual serving as Director of the Service on that day;

(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians, including by ensuring that all agency directors, managers, and chief executive officers have appropriate and adequate training, experience, skill levels, knowledge, abilities, and education (including continuing training requirements) to competently fulfill the duties of the positions and the mission of the Service;

(3) administer all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

(A) this Act;

(B) the Act of November 2, 1921¹⁸ (25 U.S.C. 13);

(C) the Act of August 5, 1954¹⁹ (42 U.S.C. 2001 et seq.);

(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

(E) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

(4) administer all scholarship and loan functions carried out under title I;

(5) directly advise the Secretary concerning the development of all policy- and budget-related matters affecting Indian health;

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

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

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

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

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

(d) AUTHORITY.—

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

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

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

¹⁸This Act is commonly referred to as the “Snyder Act”, which is included in this compilation.

¹⁹This Act is commonly referred to as the “Transfer Act”, which is included in this compilation.

(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).

AUTOMATED MANAGEMENT INFORMATION SYSTEM

SEC. 602. [25 U.S.C. 1662] (a)(1) The Secretary shall establish an automated management information system for the Service.

(2) The information system established under paragraph (1) shall include—

- (A) a financial management system,
- (B) a patient care information system for each area served by the Service,
- (C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service, and
- (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.

(b)(1) 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—

- (A) 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
- (B) meet the management information needs of the Service.

(2) The Secretary shall reimburse each Indian tribe or tribal organization for the part of the cost of the operation of a system provided under paragraph (1) which is attributable to the treatment by such Indian tribe or tribal organization of patients of the Service.

(3) The Secretary shall provide systems under paragraph (1) to Indian tribes and tribal organizations providing health services in California by no later than September 30, 1990.

(c) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

SEC. 603. [25 U.S.C. 1663] OFFICE OF DIRECT SERVICE TRIBES.

(a) **ESTABLISHMENT.**—There is established within the Service an office, to be known as the “Office of Direct Service Tribes”.

(b) **TREATMENT.**—The Office of Direct Service Tribes shall be located in the Office of the Director.

(c) **DUTIES.**—The Office of Direct Service Tribes shall be responsible for—

(1) providing Service-wide leadership, guidance and support for direct service tribes to include strategic planning and program evaluation;

(2) ensuring maximum flexibility to tribal health and related support systems for Indian beneficiaries;

(3) serving as the focal point for consultation and participation between direct service tribes and organizations and the Service in the development of Service policy;

(4) holding no less than biannual consultations with direct service tribes in appropriate locations to gather information and aid in the development of health policy; and

(5) directing a national program and providing leadership and advocacy in the development of health policy, program management, budget formulation, resource allocation, and delegation support for direct service tribes.

SEC. 604. [25 U.S.C. 1663a] NEVADA AREA OFFICE.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, in a manner consistent with the tribal consultation policy of the Service, the Secretary shall submit to Congress a plan describing the manner and schedule by which an area office, separate and distinct from the Phoenix Area Office of the Service, can be established in the State of Nevada.

(b) FAILURE TO SUBMIT PLAN.—

(1) DEFINITION OF OPERATIONS FUNDS.—In this subsection, the term “operations funds” means only the funds used for—

(A) the administration of services, including functional expenses such as overtime, personnel salaries, and associated benefits; or

(B) related tasks that directly affect the operations described in subparagraph (A).

(2) WITHHOLDING OF FUNDS.—If the Secretary fails to submit a plan in accordance with subsection (a), the Secretary shall withhold the operations funds reserved for the Office of the Director, subject to the condition that the withholding shall not adversely impact the capacity of the Service to deliver health care services.

(3) RESTORATION.—The operations funds withheld pursuant to paragraph (2) may be restored, at the discretion of the Secretary, to the Office of the Director on achievement by that Office of compliance with this section.

TITLE VII—BEHAVIORAL HEALTH PROGRAMS

Subtitle A—General Programs

SEC. 701. [25 U.S.C. 1665] DEFINITIONS.

In this subtitle:

(1) ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDERS; ARND.—The term “alcohol-related neurodevelopmental disorders” or “ARND” means, with a history of maternal alcohol consumption during pregnancy, central nervous system abnor-

malities, which may range from minor intellectual deficits and developmental delays to mental retardation. ARND children may have behavioral problems, learning disabilities, problems with executive functioning, and attention disorders. The neurological defects of ARND may be as severe as FAS, but facial anomalies and other physical characteristics are not present in ARND, thus making diagnosis difficult.

(2) **ASSESSMENT.**—The term “assessment” means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

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

(4) **DUAL DIAGNOSIS.**—The term “dual diagnosis” means co-existing substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

(5) **FETAL ALCOHOL SPECTRUM DISORDERS.**—

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

(B) **INCLUSIONS.**—The term “fetal alcohol spectrum disorders” may include—

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

(6) **FAS OR FETAL ALCOHOL SYNDROME.**—The term “FAS” or “fetal alcohol syndrome” means a syndrome in which, with a history of maternal alcohol consumption during pregnancy, the following criteria are met:

(A) Central nervous system involvement, such as mental retardation, developmental delay, intellectual deficit, microencephaly, or neurological abnormalities.

(B) Craniofacial abnormalities with at least 2 of the following:

- (i) Microphthalmia.
- (ii) Short palpebral fissures.
- (iii) Poorly developed philtrum.
- (iv) Thin upper lip.
- (v) Flat nasal bridge.
- (vi) Short upturned nose.

(C) Prenatal or postnatal growth delay.

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

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

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

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

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

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

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

(8) SUBSTANCE ABUSE.—The term “substance abuse” includes inhalant abuse.

SEC. 702. [25 U.S.C. 1665a] BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

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

(1) To authorize and direct the Secretary, acting through the Service, Indian tribes, and tribal organizations, to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs.

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

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

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

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

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

(b) PLANS.—

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

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

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

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

(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

(C) An estimate of the additional funding needed by the Service, Indian tribes, tribal organizations, and urban Indian organizations to meet their responsibilities under the plans.

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

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

(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible and if funding is available, programs including the following:

(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

(B) detoxification (social and medical);

(C) acute hospitalization;

(D) intensive outpatient/day treatment;

(E) residential treatment;

(F) transitional living for those needing a temporary, stable living environment that is supportive of treatment and recovery goals;

(G) emergency shelter;

(H) intensive case management;

(I) diagnostic services; and

(J) promotion of healthy approaches to risk and safety issues, including injury prevention.

(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

- (A) preschool and school age fetal alcohol spectrum disorder services, including assessment and behavioral intervention;
 - (B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);
 - (C) identification and treatment of co-occurring disorders and comorbidity;
 - (D) prevention of alcohol, drug, inhalant, and tobacco use;
 - (E) early intervention, treatment, and aftercare;
 - (F) promotion of healthy approaches to risk and safety issues; and
 - (G) identification and treatment of neglect and physical, mental, and sexual abuse.
- (3) ADULT CARE.—Behavioral health services for Indians from age 18 through 55, including—
- (A) early intervention, treatment, and aftercare;
 - (B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;
 - (C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;
 - (D) promotion of healthy approaches for risk-related behavior;
 - (E) treatment services for women at risk of giving birth to a child with a fetal alcohol spectrum disorder; and
 - (F) sex specific treatment for sexual assault and domestic violence.
- (4) FAMILY CARE.—Behavioral health services for families, including—
- (A) early intervention, treatment, and aftercare for affected families;
 - (B) treatment for sexual assault and domestic violence; and
 - (C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues.
- (5) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—
- (A) early intervention, treatment, and aftercare;
 - (B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;
 - (C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;
 - (D) promotion of healthy approaches to managing conditions related to aging;
 - (E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse and exploitation; and
 - (F) identification and treatment of dementias regardless of cause.
- (d) COMMUNITY BEHAVIORAL HEALTH PLAN.—
- (1) ESTABLISHMENT.—The governing body of any Indian tribe, tribal organization, or urban Indian organization may

adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat substance abuse, mental illness, or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. This plan should include behavioral health services, social services, intensive outpatient services, and continuing aftercare.

(2) **TECHNICAL ASSISTANCE.**—At the request of an Indian tribe, tribal organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian tribe, tribal organization, or urban Indian organization in the development and implementation of such plan.

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

(e) **COORDINATION FOR AVAILABILITY OF SERVICES.**—The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

(f) **MENTAL HEALTH CARE NEED ASSESSMENT.**—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

SEC. 703. [25 U.S.C. 1665b] MEMORANDA OF AGREEMENT WITH THE DEPARTMENT OF INTERIOR.

(a) **CONTENTS.**—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, and the Secretary of the Interior shall develop and enter into a memoranda of agreement, or review and update any existing memoranda of agreement, as required by section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411) under which the Secretaries address the following:

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

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

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

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

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

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

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

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

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

(B) ensuring that the Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services.

(7) Directing appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and Service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 702(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412).

(8) Providing for an annual review of such agreement by the Secretaries which shall be provided to Congress and Indian tribes and tribal organizations.

(b) SPECIFIC PROVISIONS REQUIRED.—The memoranda of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

(1) the determination of the scope of the problem of alcohol and substance abuse among Indians, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

(c) PUBLICATION.—Each memorandum of agreement entered into or renewed (and amendments or modifications thereto) under subsection (a) shall be published in the Federal Register. At the same time as publication in the Federal Register, the Secretary shall provide a copy of such memoranda, amendment, or modification to each Indian tribe, tribal organization, and urban Indian organization.

SEC. 704. [25 U.S.C. 1665c] COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, acting through the Service, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, which may include, if feasible and appropriate, systems of care, and shall include—

(A) prevention, through educational intervention, in Indian communities;

(B) acute detoxification, psychiatric hospitalization, residential, and intensive outpatient treatment;

(C) community-based rehabilitation and aftercare;

(D) community education and involvement, including extensive training of health care, educational, and community-based personnel;

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

(F) diagnostic services.

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

(b) CONTRACT HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary, acting through the Service, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

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

SEC. 705. [25 U.S.C. 1665d] MENTAL HEALTH TECHNICIAN PROGRAM.

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

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

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

(b) **PARAPROFESSIONAL TRAINING.**—In carrying out subsection (a), the Secretary, acting through the Service, shall provide high-standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

(c) **SUPERVISION AND EVALUATION OF TECHNICIANS.**—The Secretary, acting through the Service, shall supervise and evaluate the mental health technicians in the training program.

(d) **TRADITIONAL HEALTH CARE PRACTICES.**—The Secretary, acting through the Service, shall ensure that the program established pursuant to this section involves the use and promotion of the traditional health care practices of the Indian tribes to be served.

SEC. 706. [25 U.S.C. 1665e] LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

(a) **IN GENERAL.**—Subject to section 221, and except as provided in subsection (b), any individual employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under this Act is required to be licensed as a psychologist, social worker, or marriage and family therapist, respectively.

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

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

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

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

SEC. 707. [25 U.S.C. 1665f] INDIAN WOMEN TREATMENT PROGRAMS.

(a) **GRANTS.**—The Secretary, consistent with section 702, may make grants to Indian tribes, tribal organizations, and urban Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the cul-

tural, historical, social, and child care needs of Indian women, regardless of age.

(b) **USE OF GRANT FUNDS.**—A grant made pursuant to this section may be used—

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

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

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

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

(d) **ALLOCATION OF FUNDS FOR URBAN INDIAN ORGANIZATIONS.**—20 percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian organizations.

SEC. 708. [25 U.S.C. 1665g] INDIAN YOUTH PROGRAM.

(a) **DETOXIFICATION AND REHABILITATION.**—The Secretary, acting through the Service, consistent with section 702, shall develop and implement a program for acute detoxification and treatment for Indian youths, including behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

(b) **ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.**—

(1) **ESTABLISHMENT.**—

(A) **IN GENERAL.**—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an area office.

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

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

(3) **LOCATION.**—A youth treatment center constructed or purchased under this subsection shall be constructed or pur-

chased at a location within the area described in paragraph (1) agreed upon (by appropriate tribal resolution) by a majority of the Indian tribes to be served by such center.

(4) SPECIFIC PROVISION OF FUNDS.—

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

(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska; and

(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l)).

(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—

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

(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary, acting through the Service, may provide intermediate behavioral health services, which may, if feasible and appropriate, incorporate systems of care, to Indian children and adolescents, including—

(A) pretreatment assistance;

(B) inpatient, outpatient, and aftercare services;

(C) emergency care;

(D) suicide prevention and crisis intervention; and

(E) prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence.

(2) USE OF FUNDS.—Funds provided under this subsection may be used—

(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

(B) to hire behavioral health professionals;

(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided;

(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

(E) for intensive home- and community-based services.

(3) CRITERIA.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applica-

tions or proposals for funding made available pursuant to this subsection.

(d) **FEDERALLY OWNED STRUCTURES.**—

(1) **IN GENERAL.**—The Secretary, in consultation with Indian tribes and tribal organizations, shall—

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

(B) establish guidelines for determining the suitability of any such federally owned structure to be used for local residential or regional behavioral health treatment for Indian youths.

(2) **TERMS AND CONDITIONS FOR USE OF STRUCTURE.**—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

(e) **REHABILITATION AND AFTERCARE SERVICES.**—

(1) **IN GENERAL.**—The Secretary, Indian tribes, or tribal organizations, in cooperation with the Secretary of the Interior, shall develop and implement within each Service unit, community-based rehabilitation and follow-up services for Indian youths who are having significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youths after their return to their home community.

(2) **ADMINISTRATION.**—Services under paragraph (1) shall be provided by trained staff within the community who can assist the Indian youths in their continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

(f) **INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.**—In providing the treatment and other services to Indian youths authorized by this section, the Secretary, acting through the Service, shall provide for the inclusion of family members of such youths in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

(g) **MULTIDRUG ABUSE PROGRAM.**—The Secretary, acting through the Service, shall provide, consistent with section 702, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youths residing in Indian communities, on or near reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youths.

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

(1) the number of Indian youth who are being provided mental health services through the Service and tribal health programs;

(2) a description of, and costs associated with, the mental health services provided for Indian youth through the Service and tribal health programs;

(3) the number of youth referred to the Service or tribal health programs for mental health services;

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

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

SEC. 709. [25 U.S.C. 1665h] INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION, AND STAFFING.

Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary, acting through the Service, may provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems. For the purposes of this subsection, California shall be considered to be 2 area offices, 1 office whose location shall be considered to encompass the northern area of the State of California and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California. The Secretary shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

SEC. 710. [25 U.S.C. 1665i] TRAINING AND COMMUNITY EDUCATION.

(a) PROGRAM.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement or assist Indian tribes and tribal organizations to develop and implement, within each Service unit or tribal program, a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community. Such program shall include education about behavioral health issues to political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health care providers including traditional practitioners, and other critical members of each tribal community. Such program may also include community-based training to develop local capacity and tribal community provider training for prevention, intervention, treatment, and aftercare.

(b) INSTRUCTION.—The Secretary, acting through the Service, shall 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 spectrum disorders to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol

and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

(c) **TRAINING MODELS.**—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

- (1) the elevated risk of alcohol abuse and other behavioral health problems faced by children of alcoholics;
- (2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and
- (3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

SEC. 711. [25 U.S.C. 1665j] BEHAVIORAL HEALTH PROGRAM.

(a) **INNOVATIVE PROGRAMS.**—The Secretary, acting through the Service, consistent with section 702, may plan, develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

(b) **AWARDS; CRITERIA.**—The Secretary may award a grant for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

- (1) The project will address significant unmet behavioral health needs among Indians.
- (2) The project will serve a significant number of Indians.
- (3) The project has the potential to deliver services in an efficient and effective manner.
- (4) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.
- (5) The project may deliver services in a manner consistent with traditional health care practices.
- (6) The project is coordinated with, and avoids duplication of, existing services.

(c) **EQUITABLE TREATMENT.**—For purposes of this subsection, the Secretary shall, in evaluating project applications or proposals, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

SEC. 712. [25 U.S.C. 1665k] FETAL ALCOHOL SPECTRUM DISORDERS PROGRAMS.

(a) **PROGRAMS.**—

(1) **ESTABLISHMENT.**—The Secretary, consistent with section 702, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol spectrum disorders programs as provided in this section for the purposes of meeting the health status objectives specified in section 3.

(2) **USE OF FUNDS.**—

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

- (i) To develop and provide for Indians community and in-school training, education, and prevention programs relating to fetal alcohol spectrum disorders.

(ii) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian's child.

(iii) To identify and provide appropriate psychological services, educational and vocational support, counseling, advocacy, and information to fetal alcohol spectrum disorders-affected Indians and their families or caretakers.

(iv) To develop and implement counseling and support programs in schools for fetal alcohol spectrum disorders-affected Indian children.

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

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

(vii) To develop and implement, in consultation with Indian Tribes and Tribal Organizations, and in conference with urban Indian Organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban Centers.

(viii) To develop and provide training on fetal alcohol spectrum disorders to professionals providing services to Indians, including medical and allied health practitioners, social service providers, educators, and law enforcement, court officials and corrections personnel in the juvenile and criminal justice systems.

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

(i) Early childhood intervention projects from birth on to mitigate the effects of fetal alcohol spectrum disorders among Indians.

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

(iii) Community-based housing for adult Indians with fetal alcohol spectrum disorders.

(3) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

(b) SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, shall—

(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol spectrum disorders in Indian communities; and

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

(c) **APPLIED RESEARCH PROJECTS.**—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian Tribes, Tribal Organizations, and urban Indian Organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

(d) **FUNDING FOR URBAN INDIAN ORGANIZATIONS.**—Ten percent of the funds appropriated pursuant to this section shall be used to make grants to urban Indian Organizations funded under title V.

SEC. 713. [25 U.S.C. 1665i] CHILD SEXUAL ABUSE PREVENTION AND TREATMENT PROGRAMS.

(a) **ESTABLISHMENT.**—The Secretary, acting through the Service, shall establish, consistent with section 702, in every Service area, programs involving treatment for—

- (1) victims of sexual abuse who are Indian children or children in an Indian household; and
- (2) other members of the household or family of the victims described in paragraph (1).

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

- (1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.
- (2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.
- (3) To develop prevention and intervention models which incorporate traditional health care practices, cultural values, and community involvement.
- (4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and urban centers.

(c) **COORDINATION.**—The programs established under subsection (a) shall be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3201 et seq.).

SEC. 714. [25 U.S.C. 1665m] DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.

(a) **IN GENERAL.**—The Secretary, in accordance with section 702, is authorized to establish in each Service area programs involving the prevention and treatment of—

- (1) Indian victims of domestic violence or sexual abuse; and
- (2) other members of the household or family of the victims described in paragraph (1).

(b) **USE OF FUNDS.**—Funds made available to carry out this section shall be used—

- (1) to develop and implement prevention programs and community education programs relating to domestic violence and sexual abuse;

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

(3) to purchase rape kits; and

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

(c) TRAINING AND CERTIFICATION.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall establish appropriate protocols, policies, procedures, standards of practice, and, if not available elsewhere, training curricula and training and certification requirements for services for victims of domestic violence and sexual abuse.

(2) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

(d) COORDINATION.—

(1) IN GENERAL.—The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian health programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

(A) to improve domestic violence or sexual abuse responses;

(B) to improve forensic examinations and collection;

(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

(2) REPORT.—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

SEC. 715. [25 U.S.C. 1665n] BEHAVIORAL HEALTH RESEARCH.

(a) IN GENERAL.—The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian tribes, tribal organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by

the Service, Indian tribes, or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

(1) the multifactorial causes of Indian youth suicide, including—

(A) protective and risk factors and scientific data that identifies those factors; and

(B) the effects of loss of cultural identity and the development of scientific data on those effects;

(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

(3) the development of models of prevention techniques.

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

Subtitle B—Indian Youth Suicide Prevention

SEC. 721. [25 U.S.C. 1667] FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1)(A) the rate of suicide of American Indians and Alaska Natives is 1.9 times higher than the national average rate; and

(B) the rate of suicide of Indian and Alaska Native youth aged 15 through 24 is—

(i) 3.5 times the national average rate; and

(ii) the highest rate of any population group in the United States;

(2) many risk behaviors and contributing factors for suicide are more prevalent in Indian country than in other areas, including—

(A) history of previous suicide attempts;

(B) family history of suicide;

(C) history of depression or other mental illness;

(D) alcohol or drug abuse;

(E) health disparities;

(F) stressful life events and losses;

(G) easy access to lethal methods;

(H) exposure to the suicidal behavior of others;

(I) isolation; and

(J) incarceration;

(3) according to national data for 2005, suicide was the second-leading cause of death for Indians and Alaska Natives of both sexes aged 10 through 34;

(4)(A) the suicide rates of Indian and Alaska Native males aged 15 through 24 are—

(i) as compared to suicide rates of males of any other racial group, up to 4 times greater; and

(ii) as compared to suicide rates of females of any other racial group, up to 11 times greater; and

(B) data demonstrates that, over their lifetimes, females attempt suicide 2 to 3 times more often than males;

(5)(A) Indian tribes, especially Indian tribes located in the Great Plains, have experienced epidemic levels of suicide, up to 10 times the national average; and

(B) suicide clustering in Indian country affects entire tribal communities;

(6) death rates for Indians and Alaska Natives are statistically underestimated because many areas of Indian country lack the proper resources to identify and monitor the presence of disease;

(7)(A) the Indian Health Service experiences health professional shortages, with physician vacancy rates of approximately 17 percent, and nursing vacancy rates of approximately 18 percent, in 2007;

(B) 90 percent of all teens who die by suicide suffer from a diagnosable mental illness at time of death;

(C) more than $\frac{1}{2}$ of teens who die by suicide have never been seen by a mental health provider; and

(D) $\frac{1}{3}$ of health needs in Indian country relate to mental health;

(8) often, the lack of resources of Indian tribes and the remote nature of Indian reservations make it difficult to meet the requirements necessary to access Federal assistance, including grants;

(9) the Substance Abuse and Mental Health Services Administration and the Service have established specific initiatives to combat youth suicide in Indian country and among Indians and Alaska Natives throughout the United States, including the National Suicide Prevention Initiative of the Service, which has worked with Service, tribal, and urban Indian health programs since 2003;

(10) the National Strategy for Suicide Prevention was established in 2001 through a Department of Health and Human Services collaboration among—

(A) the Substance Abuse and Mental Health Services Administration;

(B) the Service;

(C) the Centers for Disease Control and Prevention;

(D) the National Institutes of Health; and

(E) the Health Resources and Services Administration;

and

(11) the Service and other agencies of the Department of Health and Human Services use information technology and other programs to address the suicide prevention and mental health needs of Indians and Alaska Natives.

(b) PURPOSES.—The purposes of this subtitle are—

(1) to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth, including through—

(A) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health condi-

tions predisposing to suicide, and alcohol and substance abuse treatment;

(B) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

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

(D) the development of culturally relevant educational materials on suicide; and

(E) data collection and reporting;

(2) to encourage Indian tribes, tribal organizations, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns; and

(3) to enhance the provision of mental health care services to Indian youth through existing grant programs of the Substance Abuse and Mental Health Services Administration.

SEC. 722. [25 U.S.C. 1667a] DEFINITIONS.

In this subtitle:

(1) **ADMINISTRATION.**—The term “Administration” means the Substance Abuse and Mental Health Services Administration.

(2) **DEMONSTRATION PROJECT.**—The term “demonstration project” means the Indian youth telemental health demonstration project authorized under section 723(a).

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

SEC. 723. [25 U.S.C. 1667b] INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT.

(a) **AUTHORIZATION.**—

(1) **IN GENERAL.**—The Secretary, acting through the Service, is authorized to carry out a demonstration project to award grants for the provision of telemental health services to Indian youth who—

(A) have expressed suicidal ideas;

(B) have attempted suicide; or

(C) have behavioral health conditions that increase or could increase the risk of suicide.

(2) **ELIGIBILITY FOR GRANTS.**—Grants under paragraph (1) shall be awarded to Indian tribes and tribal organizations that operate 1 or more facilities—

(A) located in an area with documented disproportionately high rates of suicide;

(B) reporting active clinical telehealth capabilities; or

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

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

(4) MAXIMUM NUMBER OF GRANTS.—Not more than 5 grants shall be provided under paragraph (1), with priority consideration given to Indian tribes and tribal organizations that—

(A) serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide;

(B) enter into collaborative partnerships with Service or other tribal health programs or facilities to provide services under this demonstration project;

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

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

(5) CONSULTATION WITH ADMINISTRATION.—In developing and carrying out the demonstration project under this subsection, the Secretary shall consult with the Administration as the Federal agency focused on mental health issues, including suicide.

(b) USE OF FUNDS.—

(1) IN GENERAL.—An Indian tribe or tribal organization shall use a grant received under subsection (a) for the following purposes:

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

(i) psychotherapy;

(ii) psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and

(iii) alcohol and substance abuse treatment.

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

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

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

(i) suicide prevention;

(ii) suicide education;

(iii) suicide screening;

(iv) suicide intervention; and

(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

(E) To conduct data collection and reporting relating to Indian youth suicide prevention efforts.

(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian tribe or tribal organization may use and promote the traditional health care practices of the Indian tribes of the youth to be served.

(c) APPLICATIONS.—

(1) IN GENERAL.—Subject to paragraph (2), to be eligible to receive a grant under subsection (a), an Indian tribe or tribal organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(A) a description of the project that the Indian tribe or tribal organization will carry out using the funds provided under the grant;

(B) a description of the manner in which the project funded under the grant would—

(i) meet the telemental health care needs of the Indian youth population to be served by the project; or

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

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

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

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

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

(2) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under paragraph (1).

(d) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian tribes and tribal organizations receiving grants under this section to collaborate to enable comparisons regarding best practices across projects.

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

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

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

(f) REPORTS TO CONGRESS.—

(1) INITIAL REPORT.—

(A) IN GENERAL.—Not later than 2 years after the date on which the first grant is awarded under this section, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a report that—

(i) describes each project funded by a grant under this section during the preceding 2-year period, including a description of the level of success achieved by the project; and

(ii) evaluates whether the demonstration project should be continued during the period beginning on the date of termination of funding for the demonstration project under subsection (g) and ending on the date on which the final report is submitted under paragraph (2).

(B) CONTINUATION OF DEMONSTRATION PROJECT.—On a determination by the Secretary under clause (ii) of subparagraph (A) that the demonstration project should be continued, the Secretary may carry out the demonstration project during the period described in that clause using such sums otherwise made available to the Secretary as the Secretary determines to be appropriate.

(2) FINAL REPORT.—Not later than 270 days after the date of termination of funding for the demonstration project under subsection (g), the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Committee on Energy and Commerce of the House of Representatives a final report that—

(A) describes the results of the projects funded by grants awarded under this section, including any data available that indicate the number of attempted suicides;

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

(C) evaluates whether the demonstration project should be—

(i) expanded to provide more than 5 grants; and

(ii) designated as a permanent program; and

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

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$1,500,000 for each of fiscal years 2010 through 2013.

SEC. 724. [25 U.S.C. 1667c] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION GRANTS.

(a) GRANT APPLICATIONS.—

(1) EFFICIENCY OF GRANT APPLICATION PROCESS.—The Secretary, acting through the Administration, shall carry out such measures as the Secretary determines to be necessary to maximize the time and workload efficiency of the process by which Indian tribes and tribal organizations apply for grants under any program administered by the Administration, including by

providing methods other than electronic methods of submitting applications for those grants, if necessary.

(2) PRIORITY FOR CERTAIN GRANTS.—

(A) IN GENERAL.—To fulfill the trust responsibility of the United States to Indian tribes, in awarding relevant grants pursuant to a program described in subparagraph (B), the Secretary shall take into consideration the needs of Indian tribes or tribal organizations, as applicable, that serve populations with documented high suicide rates, regardless of whether those Indian tribes or tribal organizations possess adequate personnel or infrastructure to fulfill all applicable requirements of the relevant program.

(B) DESCRIPTION OF GRANT PROGRAMS.—A grant program referred to in subparagraph (A) is a grant program—

(i) administered by the Administration to fund activities relating to mental health, suicide prevention, or suicide-related risk factors; and

(ii) under which an Indian tribe or tribal organization is an eligible recipient.

(3) CLARIFICATION REGARDING INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Notwithstanding any other provision of law, in applying for a grant under any program administered by the Administration, no Indian tribe or tribal organization shall be required to apply through a State or State agency.

(4) REQUIREMENTS FOR AFFECTED STATES.—

(A) DEFINITIONS.—In this paragraph:

(i) AFFECTED STATE.—The term “affected State” means a State—

(I) the boundaries of which include 1 or more Indian tribes; and

(II) the application for a grant under any program administered by the Administration of which includes statewide data.

(ii) INDIAN POPULATION.—The term “Indian population” means the total number of residents of an affected State who are Indian.

(B) REQUIREMENTS.—As a condition of receipt of a grant under any program administered by the Administration, each affected State shall—

(i) describe in the grant application—

(I) the Indian population of the affected State; and

(II) the contribution of that Indian population to the statewide data used by the affected State in the application; and

(ii) demonstrate to the satisfaction of the Secretary that—

(I) of the total amount of the grant, the affected State will allocate for use for the Indian population of the affected State an amount equal to the proportion that—

(aa) the Indian population of the affected State; bears to

(bb) the total population of the affected State; and

(II) the affected State will take reasonable efforts to collaborate with each Indian tribe located within the affected State to carry out youth suicide prevention and treatment measures for members of the Indian tribe.

(C) REPORT.—Not later than 1 year after the date of receipt of a grant described in subparagraph (B), an affected State shall submit to the Secretary a report describing the measures carried out by the affected State to ensure compliance with the requirements of subparagraph (B)(ii).

(b) NO NON-FEDERAL SHARE REQUIREMENT.—Notwithstanding any other provision of law, no Indian tribe or tribal organization shall be required to provide a non-Federal share of the cost of any project or activity carried out using a grant provided under any program administered by the Administration.

(c) OUTREACH FOR RURAL AND ISOLATED INDIAN TRIBES.—Due to the rural, isolated nature of most Indian reservations and communities (especially those reservations and communities in the Great Plains region), the Secretary shall conduct outreach activities, with a particular emphasis on the provision of telemental health services, to achieve the purposes of this subtitle with respect to Indian tribes located in rural, isolated areas.

(d) PROVISION OF OTHER ASSISTANCE.—

(1) IN GENERAL.—The Secretary, acting through the Administration, shall carry out such measures (including monitoring and the provision of required assistance) as the Secretary determines to be necessary to ensure the provision of adequate suicide prevention and mental health services to Indian tribes described in paragraph (2), regardless of whether those Indian tribes possess adequate personnel or infrastructure—

(A) to submit an application for a grant under any program administered by the Administration, including due to problems relating to access to the Internet or other electronic means that may have resulted in previous obstacles to submission of a grant application; or

(B) to fulfill all applicable requirements of the relevant program.

(2) DESCRIPTION OF INDIAN TRIBES.—An Indian tribe referred to in paragraph (1) is an Indian tribe—

(A) the members of which experience—

- (i) a high rate of youth suicide;
- (ii) low socioeconomic status; and
- (iii) extreme health disparity;

(B) that is located in a remote and isolated area; and

(C) that lacks technology and communication infrastructure.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as the Secretary determines to be necessary to carry out this subsection.

(e) EARLY INTERVENTION AND ASSESSMENT SERVICES.—

(1) **DEFINITION OF AFFECTED ENTITY.**—In this subsection, the term “affected entity” means any entity—

(A) that receives a grant for suicide intervention, prevention, or treatment under a program administered by the Administration; and

(B) the population to be served by which includes Indian youth.

(2) **REQUIREMENT.**—The Secretary, acting through the Administration, shall ensure that each affected entity carrying out a youth suicide early intervention and prevention strategy described in section 520E(c)(1) of the Public Health Service Act (42 U.S.C. 290bb–36(c)(1)), or any other youth suicide-related early intervention and assessment activity, provides training or education to individuals who interact frequently with the Indian youth to be served by the affected entity (including parents, teachers, coaches, and mentors) on identifying warning signs of Indian youth who are at risk of committing suicide.

SEC. 725. [25 U.S.C. 1667d] USE OF PREDOCTORAL PSYCHOLOGY AND PSYCHIATRY INTERNS.

The Secretary shall carry out such activities as the Secretary determines to be necessary to encourage Indian tribes, tribal organizations, and other mental health care providers to obtain the services of predoctoral psychology and psychiatry interns—

(1) to increase the quantity of patients served by the Indian tribes, tribal organizations, and other mental health care providers; and

(2) for purposes of recruitment and retention.

SEC. 726. [25 U.S.C. 1667e] INDIAN YOUTH LIFE SKILLS DEVELOPMENT DEMONSTRATION PROGRAM.

(a) **PURPOSE.**—The purpose of this section is to authorize the Secretary, acting through the Administration, to carry out a demonstration program to test the effectiveness of a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide, including through—

(1) the establishment of tribal partnerships to develop and implement such a curriculum, in cooperation with—

(A) behavioral health professionals, with a priority for tribal partnerships cooperating with mental health professionals employed by the Service;

(B) tribal or local school agencies; and

(C) parent and community groups;

(2) the provision by the Administration or the Service of—

(A) technical expertise; and

(B) clinicians, analysts, and educators, as appropriate;

(3) training for teachers, school administrators, and community members to implement the curriculum;

(4) the establishment of advisory councils composed of parents, educators, community members, trained peers, and others to provide advice regarding the curriculum and other components of the demonstration program;

(5) the development of culturally appropriate support measures to supplement the effectiveness of the curriculum; and

(6) projects modeled after evidence-based projects, such as programs evaluated and published in relevant literature.

(b) DEMONSTRATION GRANT PROGRAM.—

(1) DEFINITIONS.—In this subsection:

(A) CURRICULUM.—The term “curriculum” means the culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide identified by the Secretary under paragraph (2)(A).

(B) ELIGIBLE ENTITY.—The term “eligible entity” means—

- (i) an Indian tribe;
- (ii) a tribal organization;
- (iii) any other tribally authorized entity; and
- (iv) any partnership composed of 2 or more entities described in clause (i), (ii), or (iii).

(2) ESTABLISHMENT.—The Secretary, acting through the Administration, may establish and carry out a demonstration program under which the Secretary shall—

(A) identify a culturally compatible, school-based, life skills curriculum for the prevention of Indian and Alaska Native adolescent suicide;

(B) identify the Indian tribes that are at greatest risk for adolescent suicide;

(C) invite those Indian tribes to participate in the demonstration program by—

(i) responding to a comprehensive program requirement request of the Secretary; or

(ii) submitting, through an eligible entity, an application in accordance with paragraph (4); and

(D) provide grants to the Indian tribes identified under subparagraph (B) and eligible entities to implement the curriculum with respect to Indian and Alaska Native youths who—

- (i) are between the ages of 10 and 19; and
- (ii) attend school in a region that is at risk of high youth suicide rates, as determined by the Administration.

(3) REQUIREMENTS.—

(A) TERM.—The term of a grant provided under the demonstration program under this section shall be not less than 4 years.

(B) MAXIMUM NUMBER.—The Secretary may provide not more than 5 grants under the demonstration program under this section.

(C) AMOUNT.—The grants provided under this section shall be of equal amounts.

(D) CERTAIN SCHOOLS.—In selecting eligible entities to receive grants under this section, the Secretary shall ensure that not less than 1 demonstration program shall be carried out at each of—

- (i) a school operated by the Bureau of Indian Education;
- (ii) a Tribal school; and

(iii) a school receiving payments under section 7002 or 7003 of the Elementary and Secondary Education Act of 1965.

(4) APPLICATIONS.—To be eligible to receive a grant under the demonstration program, an eligible entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

(A) an assurance that, in implementing the curriculum, the eligible entity will collaborate with 1 or more local educational agencies, including elementary schools, middle schools, and high schools;

(B) an assurance that the eligible entity will collaborate, for the purpose of curriculum development, implementation, and training and technical assistance, with 1 or more—

(i) nonprofit entities with demonstrated expertise regarding the development of culturally sensitive, school-based, youth suicide prevention and intervention programs; or

(ii) institutions of higher education with demonstrated interest and knowledge regarding culturally sensitive, school-based, life skills youth suicide prevention and intervention programs;

(C) an assurance that the curriculum will be carried out in an academic setting in conjunction with at least 1 classroom teacher not less frequently than twice each school week for the duration of the academic year;

(D) a description of the methods by which curriculum participants will be—

(i) screened for mental health at-risk indicators; and

(ii) if needed and on a case-by-case basis, referred to a mental health clinician for further assessment and treatment and with crisis response capability; and

(E) an assurance that supportive services will be provided to curriculum participants identified as high-risk participants, including referral, counseling, and follow-up services for—

(i) drug or alcohol abuse;

(ii) sexual or domestic abuse; and

(iii) depression and other relevant mental health concerns.

(5) USE OF FUNDS.—An Indian tribe identified under paragraph (2)(B) or an eligible entity may use a grant provided under this subsection—

(A) to develop and implement the curriculum in a school-based setting;

(B) to establish an advisory council—

(i) to advise the Indian tribe or eligible entity regarding curriculum development; and

(ii) to provide support services identified as necessary by the community being served by the Indian tribe or eligible entity;

(C) to appoint and train a school- and community-based cultural resource liaison, who will act as an intermediary among the Indian tribe or eligible entity, the applicable school administrators, and the advisory council established by the Indian tribe or eligible entity;

(D) to establish an on-site, school-based, MA- or PhD-level mental health practitioner (employed by the Service, if practicable) to work with tribal educators and other personnel;

(E) to provide for the training of peer counselors to assist in carrying out the curriculum;

(F) to procure technical and training support from nonprofit or State entities or institutions of higher education identified by the community being served by the Indian tribe or eligible entity as the best suited to develop and implement the curriculum;

(G) to train teachers and school administrators to effectively carry out the curriculum;

(H) to establish an effective referral procedure and network;

(I) to identify and develop culturally compatible curriculum support measures;

(J) to obtain educational materials and other resources from the Administration or other appropriate entities to ensure the success of the demonstration program; and

(K) to evaluate the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide.

(c) EVALUATIONS.—Using such amounts made available pursuant to subsection (e) as the Secretary determines to be appropriate, the Secretary shall conduct, directly or through a grant, contract, or cooperative agreement with an entity that has experience regarding the development and operation of successful culturally compatible, school-based, life skills suicide prevention and intervention programs or evaluations, an annual evaluation of the demonstration program under this section, including an evaluation of—

(1) the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

(2) areas for program improvement; and

(3) additional development of the goals and objectives of the demonstration program.

(d) REPORT TO CONGRESS.—

(1) IN GENERAL.—Subject to paragraph (2), not later than 180 days after the date of termination of the demonstration program, the Secretary shall submit to the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Natural Resources and the Committee on Education and Labor of the House of Representatives a final report that—

(A) describes the results of the program of each Indian tribe or eligible entity under this section;

(B) evaluates the effectiveness of the curriculum in preventing Indian and Alaska Native adolescent suicide;

(C) makes recommendations regarding—

(i) the expansion of the demonstration program under this section to additional eligible entities;

(ii) designating the demonstration program as a permanent program; and

(iii) identifying and distributing the curriculum through the Suicide Prevention Resource Center of the Administration; and

(D) incorporates any public comments received under paragraph (2).

(2) PUBLIC COMMENT.—The Secretary shall provide a notice of the report under paragraph (1) and an opportunity for public comment on the report for a period of not less than 90 days before submitting the report to Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$1,000,000 for each of fiscal years 2010 through 2014.

TITLE VIII—MISCELLANEOUS

REPORTS

SEC. 801. [25 U.S.C. 1671] 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;

(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;

(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; and

(D) comparing such rates of use with rates of use among comparable non-Indian populations.

(4) a separate statement which specifies the amount of funds requested to carry out the provisions of section 201;

(5) a separate statement of the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in section 814, relating to infant and maternal mortality and fetal alcohol syndrome;

(6) the reports required by sections 3(d), 108(n), 203(b), 209(j), 301(c), 302(g), 305(a)(3), 403, 708(e), and 817(a), and 822(f);

(7) for fiscal year 1995, the report required by sections 702(c)(3) and 713(b);

(8) for fiscal year 1997, the interim report required by section 307(h)(1); and

(9) for fiscal year 1999, the reports required by sections 307(h)(2), 512(b), 711(f), and 821(g).

REGULATIONS

SEC. 802. [25 U.S.C. 1672] Prior to any revision of or amendment to rules or regulations promulgated pursuant to this Act, the Secretary shall consult with Indian tribes and appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

[Section 803 repealed by section 901(4) of P.L. 102-573]

LEASES WITH INDIAN TRIBES

SEC. 804. [25 U.S.C. 1674] (a) 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 for periods not in excess of twenty years. Property leased by the Secretary from an Indian tribe may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe.

(b) 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. 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.

SEC. 805. [25 U.S.C. 1675] CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS; QUALIFIED IMMUNITY FOR PARTICIPANTS.

(a) DEFINITIONS.—In this section:

(1) HEALTH CARE PROVIDER.—The term “health care provider” means any health care professional, including community health aides and practitioners certified under section 119, who is—

(A) granted clinical practice privileges or employed to provide health care services at—

(i) an Indian health program; or

(ii) a health program of an urban Indian organization; and

(B) licensed or certified to perform health care services by a governmental board or agency or professional health care society or organization.

(2) MEDICAL QUALITY ASSURANCE PROGRAM.—The term “medical quality assurance program” means any activity carried out before, on, or after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 by or for any Indian health program or urban Indian organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian health program or urban Indian organization medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentials, infection control, patient safety, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review, and identification and prevention of medical or dental incidents and risks.

(3) MEDICAL QUALITY ASSURANCE RECORD.—The term “medical quality assurance record” means the proceedings, records, minutes, and reports that—

(A) emanate from quality assurance program activities described in paragraph (2); and

(B) are produced or compiled by or for an Indian health program or urban Indian organization as part of a medical quality assurance program.

(b) CONFIDENTIALITY OF RECORDS.—Medical quality assurance records created by or for any Indian health program or a health program of an urban Indian organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (d).

(c) PROHIBITION ON DISCLOSURE AND TESTIMONY.—

(1) IN GENERAL.—No part of any medical quality assurance record described in subsection (b) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (d).

(2) TESTIMONY.—An individual who reviews or creates medical quality assurance records for any Indian health program or urban Indian organization who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

(d) AUTHORIZED DISCLOSURE AND TESTIMONY.—

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

(A) To a Federal agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to any Indian health pro-

gram or to a health program of an urban Indian organization to perform monitoring, required by law, of such program or organization.

(B) To an administrative or judicial proceeding commenced by a present or former Indian health program or urban Indian organization provider concerning the termination, suspension, or limitation of clinical privileges of such health care provider.

(C) To a governmental board or agency or to a professional health care society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any health care provider who is or was an employee of any Indian health program or urban Indian organization.

(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any health care provider who is or was an employee of any Indian health program or urban Indian organization and who has applied for or been granted authority or employment to provide health care services in or on behalf of such program or organization.

(E) To an officer, employee, or contractor of the Indian health program or urban Indian organization that created the records or for which the records were created. If that officer, employee, or contractor has a need for such record or testimony to perform official duties.

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

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

(2) **IDENTITY OF PARTICIPANTS.**—With the exception of the subject of a quality assurance action, the identity of any person receiving health care services from any Indian health program or urban Indian organization or the identity of any other person associated with such program or organization for purposes of a medical quality assurance program that is disclosed in a medical quality assurance record described in subsection (b) shall be deleted from that record or document before any disclosure of such record is made outside such program or organization.

(e) **DISCLOSURE FOR CERTAIN PURPOSES.**—

(1) **IN GENERAL.**—Nothing in this section shall be construed as authorizing or requiring the withholding from any person or entity aggregate statistical information regarding the

results of any Indian health program or urban Indian organization's medical quality assurance programs.

(2) WITHHOLDING FROM CONGRESS.—Nothing in this section shall be construed as authority to withhold any medical quality assurance record from a committee of either House of Congress, any joint committee of Congress, or the Government Accountability Office if such record pertains to any matter within their respective jurisdictions.

(f) PROHIBITION ON DISCLOSURE OF RECORD OR TESTIMONY.—An individual or entity having possession of or access to a record or testimony described by this section may not disclose the contents of such record or testimony in any manner or for any purpose except as provided in this section.

(g) EXEMPTION FROM FREEDOM OF INFORMATION ACT.—Medical quality assurance records described in subsection (b) may not be made available to any person under section 552 of title 5, United States Code.

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

(i) APPLICATION TO INFORMATION IN CERTAIN OTHER RECORDS.—Nothing in this section shall be construed as limiting access to the information in a record created and maintained outside a medical quality assurance program, including a patient's medical records, on the grounds that the information was presented during meetings of a review body that are part of a medical quality assurance program.

(j) REGULATIONS.—The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

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

(l) INCONSISTENCIES.—To the extent that the protections under part C of title IX of the Public Health Service Act (42 U.S.C. 229b–21 et seq.) (as amended by the Patient Safety and Quality Improvement Act of 2005 (Public Law 109–41; 119 Stat. 424)) and this section are inconsistent, the provisions of whichever is more protective shall control.

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

LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE

SEC. 806. [25 U.S.C. 1676] (a) HHS APPROPRIATIONS.—Any limitation on the use of funds contained in an Act providing appro-

priations for the Department of Health and Human Services for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Indian Health Service.

(b) **LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.**—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions.

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

SEC. 807. [25 U.S.C. 1677] (a) The Secretary and the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and organizations, a study of the health hazards to Indian communities as a result of nuclear resource development. Such study shall include—

(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

(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 powerplant operation and construction, and nuclear waste disposal;

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

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

(b) Upon completion of such study the Secretary and the Service shall take into account the results of such study and develop a health care plan to address the health problems studied under subsection (a). The plan shall include—

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

(2) preventive care 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 radiations, or affected by other nuclear development 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 development activities, may experience health problems.

(c) The Secretary and the Service shall submit to Congress the study prepared under subsection (a) no later than the date eighteen months after the date of enactment of this section. The health care plan prepared under subsection (b) shall be submitted in a report no later than the date one year after the date that the study prepared under subsection (a) is submitted to Congress. Such report shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the service to address such health problems.

(d)(1) There is established an Intergovernmental Task Force to be composed of the following individuals (or their designees): the Secretary of Energy, the Administrator of the Environmental Protection Agency, the Director of the Bureau of Mines²⁰, the Assistant Secretary for Occupational Safety and Health, and the Secretary of the Interior.

(2) The Task Force shall identify existing and potential operations related to nuclear resource development 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 insure that current and future health problems resulting from nuclear resource development activities are minimized or reduced.

(3) The Secretary shall be Chairman 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) In the case of any Indian who—

(1) as a result of employment in or near a uranium mine or mill, 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; 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 from such operator. 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. 808. [25 U.S.C. 1678] ARIZONA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

(a) **IN GENERAL.**—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 Indian tribes in the State of Arizona.

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

²⁰The Bureau of Mines is now the "United States Bureau of Mines" pursuant to section 10(b) of Public Law 102-285.

SEC. 808A. [25 U.S.C. 1678a] NORTH DAKOTA AND SOUTH DAKOTA AS CONTRACT HEALTH SERVICE DELIVERY AREA.

(a) **IN GENERAL.**—The States of North Dakota and South Dakota shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of Indian tribes in the States of North Dakota and South Dakota.

(b) **MAINTENANCE OF SERVICES.**—The Service shall not curtail any health care services provided to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the State of North Dakota or South Dakota if the curtailment is due to the provision of contract services in those States pursuant to the designation of the States as a contract health service delivery area by subsection (a).

SEC. 809. [25 U.S.C. 1679] ELIGIBILITY OF CALIFORNIA INDIANS.

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

- (1) Any member of a federally recognized Indian tribe.
- (2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—
 - (A) is a member of the Indian community served by a local program of the Service; and
 - (B) is regarded as an Indian by the community in which such descendant lives.
- (3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

(4) Any Indian of California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(b) **CLARIFICATION.**—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 810. [25 U.S.C. 1680] 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.

CONTRACT HEALTH FACILITIES

SEC. 811. [25 U.S.C. 1680a] The Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Service entered into under the Indian Self-Determination Act—

- (1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations,
- (2) for employee training,

(3) for cost-of-living increases for employees, and
(4) for any other expenses relating to the provision of health services,
on the same basis as such funds are provided to programs and facilities operated directly by the Service.

SEC. 812. [25 U.S.C. 1680b] NATIONAL HEALTH SERVICE CORPS.

(a) **NO REDUCTION IN SERVICES.**—The Secretary shall not remove a member of the National Health Service Corps from an Indian health program or urban Indian organization or withdraw funding used to support such a member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from the member will experience no reduction in services.

(b) **TREATMENT OF INDIAN HEALTH PROGRAMS.**—At the request of an Indian health program, the services of a member of the National Health Service Corps assigned to the Indian health program may be limited to the individuals who are eligible for services from that Indian health program.

SEC. 813. [25 U.S.C. 1680c] HEALTH SERVICES FOR INELIGIBLE PERSONS.

(a) **CHILDREN.**—Any individual who—

- (1) has not attained 19 years of age;
- (2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and
- (3) is not otherwise eligible for health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until 1 year after the date of a determination of competency.

(b) **SPOUSES.**—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of each Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

(c) **HEALTH FACILITIES PROVIDING HEALTH SERVICES.**—

(1) **IN GENERAL.**—The Secretary is authorized to provide health services under this subsection through health facilities operated directly by the Service to individuals who reside within the Service unit and who are not otherwise eligible for such health services if—

(A) the Indian tribes served by such Service unit requests such provision of health services to such individuals, and

(B) the Secretary and the served Indian tribes have jointly determined that the provision of such health services will not result in a denial or diminution of health services to eligible Indians.

(2) ISDEAA PROGRAMS.—In the case of health facilities operated under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the governing body of the Indian tribe or tribal organization providing health services under such contract or compact is authorized to determine whether health services should be provided under such contract or compact 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 consideration described in paragraph (1)(B). Any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph shall be deemed to be provided under the agreement entered into by the Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act. The provisions of section 314 of Public Law 101–512 (104 Stat. 1959), as amended by section 308 of Public Law 103–138 (107 Stat. 1416), shall apply to any services provided by the Indian tribe or tribal organization pursuant to a determination made under this subparagraph.

(3) PAYMENT FOR SERVICES.—

(A) IN GENERAL.—Persons receiving health services provided by the Service under this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 207 of this Act or any other provision of law, amounts collected under this subsection, including Medicare, Medicaid, or children's health insurance program reimbursements under titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395 et seq.), shall be credited to the account of the program providing the service and shall be used for the purposes listed in section 401(d)(2) and amounts collected under this subsection shall be available for expenditure within such program.

(B) INDIGENT PEOPLE.—Health services may be provided by the Secretary through the Service under this subsection to an indigent individual who would not be otherwise eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service

for the expenses incurred by the Service in providing such health services to such indigent individual.

(4) REVOCATION OF CONSENT FOR SERVICES.—

(A) SINGLE TRIBE SERVICE AREA.—In the case of a Service Area which serves only 1 Indian tribe, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

(B) MULTITRIBAL SERVICE AREA.—In the case of a multitribal Service Area, the authority of the Secretary to provide health services under paragraph (1) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the Service Area revoke their concurrence to the provisions of such health services.

(d) OTHER SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

- (1) achieve stability in a medical emergency;
- (2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;
- (3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through postpartum; or
- (4) provide care to immediate family members of an eligible individual if such care is directly related to the treatment of the eligible individual.

(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

(1) IN GENERAL.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) may be extended to non-Service health care practitioners who provide services to individuals described in subsection (a), (b), (c), or (d). Such non-Service health care practitioners may, as part of the privileging process, be designated as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible individuals as a part of the conditions under which such hospital privileges are extended.

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

- (A) an employee of the Service; or
- (B) an employee of an Indian tribe or tribal organization operating a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or an individual who provides health care

services pursuant to a personal services contract with such Indian tribe or tribal organization.

(f) **ELIGIBLE INDIAN.**—For purposes of this section, the term “eligible Indian” means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

INFANT AND MATERNAL MORTALITY; FETAL ALCOHOL SYNDROME

SEC. 814. [25 U.S.C. 1680d] By no later than January 1, 1990, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1994:

(1) reduction of the rate of Indian infant mortality in each area office of the Service to the lower of—

(A) twelve deaths per one thousand live births, or

(B) the rate of infant mortality applicable to the United States population as a whole;

(2) reduction of the rate of maternal mortality in each area office of the Service to the lower of—

(A) five deaths per one hundred thousand live births, or

(B) the rate of maternal mortality applicable to the United States population as a whole; and

(3) reduction of the rate of fetal alcohol syndrome among Indians served by, or on behalf of, the Service to one per one thousand live births.

CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

SEC. 815. [25 U.S.C. 1680e] (a) The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

(b) Nothing in this section may be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

INDIAN HEALTH SERVICE AND DEPARTMENT OF VETERANS AFFAIRS HEALTH FACILITIES AND SERVICES SHARING

SEC. 816. [25 U.S.C. 1680f] (a) The Secretary shall examine the feasibility of entering into an arrangement for the sharing of medical facilities and services between the Indian Health Service and the Department of Veterans Affairs and shall, in accordance with subsection (b), prepare a report on the feasibility of such an arrangement and submit such report to the Congress by no later than September 30, 1990.

(b) 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 Indian Health Service;

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

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

(4) the quality of health care services provided to any veteran by the Department of Veterans Affairs;

(5) the eligibility of any Indian to receive health services through the Indian Health Service; or

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

(c)(1) Not later than December 23, 1988, the Director of the Indian Health Service and the Secretary of Veterans Affairs shall implement an agreement under which—

(A) individuals in the vicinity of Roosevelt, Utah, who are eligible for health care from the Department of Veterans Affairs could obtain health care services at the facilities of the Indian Health Service located at Fort Duchesne, Utah; and

(B) individuals eligible for health care from the Indian Health Service at Fort Duchesne, Utah, could obtain health care services at the Department of Veterans Affairs medical center located in Salt Lake City, Utah.²¹

(2) Not later than November 23, 1990, the Secretary and the Secretary of Veterans Affairs shall jointly submit a report to the Congress on the health care services provided as a result of paragraph (1).

(d) Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Indian Health Service except as provided in an agreement under subsection (c).

REALLOCATION OF BASE RESOURCES

SEC. 817. [25 U.S.C. 1680g] (a) 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) 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.

DEMONSTRATION PROJECTS FOR TRIBAL MANAGEMENT OF HEALTH CARE SERVICES

SEC. 818. [25 U.S.C. 1680h] (a)(1) The Secretary, acting through the Service, shall make grants to Indian tribes to establish demonstration projects under which the Indian tribe will develop and test a phased approach to assumption by the Indian tribe of the health care delivery system of the Service for members of the

²¹Per section 244 of Public Law 108-170, such medical center is designated as the "George E. Wahlen Department of Veterans Affairs Medical Center".

Indian tribe living on or near the reservations of the Indian tribe through the use of Service, tribal, and private sector resources.

(2) A grant may be awarded to an Indian tribe under paragraph (1) only if the Secretary determines that the Indian tribe has the administrative and financial capabilities necessary to conduct a demonstration project described in paragraph (1).

(b) During the period in which a demonstration project established under subsection (a) is being conducted by an Indian tribe, the Secretary shall award all health care contracts, including community, behavioral, and preventive health care contracts, to the Indian tribe in the form of a single grant to which the regulations prescribed under part A of title XIX of the Public Health Service Act (as modified as necessary by any agreement entered into between the Secretary and the Indian tribe to achieve the purposes of the demonstration project established under subsection (a)) shall apply.

(c) The Secretary may waive such provisions of Federal procurement law as are necessary to enable any Indian tribe to develop and test administrative systems under the demonstration project established under subsection (a), but only if such waiver does not diminish or endanger the delivery of health care services to Indians.

(d)(1) The demonstration project established under subsection (a) shall terminate on September 30, 1993, or, in the case of a demonstration project for which a grant is made after September 30, 1990, three years after the date on which such grant is made.

(2) By no later than September 30, 1996, the Secretary shall evaluate the performance of each Indian tribe that has participated in a demonstration project established under subsection (a) and shall submit to the Congress a report on such evaluations and demonstration projects.

(e)(1) The Secretary, acting through the Service, shall make arrangements with Indian tribes to establish joint venture demonstration projects under which an Indian tribe shall expend tribal, private, or other available nontribal funds, for the acquisition or construction of a health facility for a minimum of 20 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. A tribe may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

(2) The Secretary shall make such an arrangement with an Indian tribe only if the Secretary first determines that the Indian tribe has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in paragraph (1).

(3) An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this subsection, 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 paid to a third party on the tribe's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this

section. The preceding sentence does not apply to any funds expended for the delivery of health care services, or for personnel or staffing, shall be recoverable.

CHILD SEXUAL ABUSE TREATMENT PROGRAMS

SEC. 819. [25 U.S.C. 1680i] (a) The Secretary and the Secretary of the Interior shall, for each fiscal year through fiscal year 1995, continue the demonstration programs involving treatment for child sexual abuse provided through the Hopi Tribe and the Assiniboine and Sioux Tribes of the Fort Peck Reservation.

(b) Beginning October 1, 1995, the Secretary and the Secretary of the Interior may establish, in any service area, demonstration programs involving treatment for child sexual abuse, except that the Secretaries may not establish a greater number of such programs in one service area than in any other service area until there is an equal number of such programs established with respect to all service areas from which the Secretary receives qualified applications during the application period (as determined by the Secretary).

TRIBAL LEASING

SEC. 820. [25 U.S.C. 1680j] Indian tribes providing health care services pursuant to a contract entered into under the Indian Self-Determination Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

[Section 821 repealed by section 124(a)(2) of S. 1790 (as reported by the Senate and enacted into law by section 10221(a) of Public Law 111–148; enactment date March 23, 2010.)]

SEC. 822. [25 U.S.C. 1680l] SHARED SERVICES FOR LONG-TERM CARE.

(a) LONG-TERM CARE.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary, acting through the Service, is authorized to provide directly, or enter into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian tribes or tribal organizations for, the delivery of long-term care (including health care services associated with long-term care) provided in a facility to Indians.

(2) INCLUSIONS.—Each agreement under paragraph (1) shall provide for the sharing of staff or other services between the Service or a tribal health program and a long-term care or related facility owned and operated (directly or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) by the Indian tribe or tribal organization.

(b) CONTENTS OF AGREEMENTS.—An agreement entered into pursuant to subsection (a)—

(1) may, at the request of the Indian tribe or tribal organization, delegate to the Indian tribe or tribal organization such powers of supervision and control over Service employees as the Secretary determines to be necessary to carry out the purposes of this section;

(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal health program be allocated proportionately between the Service and the Indian tribe or tribal organization; and

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

(c) **MINIMUM REQUIREMENT.**—Any nursing facility provided for under this section shall meet the requirements for nursing facilities under section 1919 of the Social Security Act (42 U.S.C. 1396r).

(d) **OTHER ASSISTANCE.**—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section.

(e) **USE OF EXISTING OR UNDERUSED FACILITIES.**—The Secretary shall encourage the use of existing facilities that are underused, or allow the use of swing beds, for long-term or similar care.

RESULTS OF DEMONSTRATION PROJECTS

SEC. 823. [25 U.S.C. 1680m] The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

PRIORITY FOR INDIAN RESERVATIONS

SEC. 824. [25 U.S.C. 1680n] (a) Beginning on the date of the enactment of this section, 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 tribe with jurisdiction over such lands.

(b) For purposes of this section, the term “Indian lands” means—

(1) all lands within the limits of any Indian reservation; and

(2) any lands title 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.

SEC. 825. [25 U.S.C. 1680o] AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2010 and each fiscal year thereafter, to remain available until expended.

SEC. 826. [25 U.S.C. 1680p] ANNUAL BUDGET SUBMISSION.

Effective beginning with the submission of the annual budget request to Congress for fiscal year 2011, the President shall include, in the amount requested and the budget justification, amounts that reflect any changes in—

(1) the cost of health care services, as indexed for United States dollar inflation (as measured by the Consumer Price Index); and

(2) the size of the population served by the Service.

SEC. 827. [25 U.S.C. 1680q] PRESCRIPTION DRUG MONITORING.

(a) MONITORING.—

(1) **ESTABLISHMENT.**—The Secretary, in coordination with the Secretary of the Interior and the Attorney General, shall establish a prescription drug monitoring program, to be carried out at health care facilities of the Service, tribal health care facilities, and urban Indian health care facilities.

(2) **REPORT.**—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

(A) the needs of the Service, tribal health care facilities, and urban Indian health care facilities with respect to the prescription drug monitoring program under paragraph (1);

(B) the planned development of that program, including any relevant statutory or administrative limitations; and

(C) the means by which the program could be carried out in coordination with any State prescription drug monitoring program.

(b) ABUSE.—

(1) **IN GENERAL.**—The Attorney General, in conjunction with the Secretary and the Secretary of the Interior, shall conduct—

(A) an assessment of the capacity of, and support required by, relevant Federal and tribal agencies—

(i) to carry out data collection and analysis regarding incidents of prescription drug abuse in Indian communities; and

(ii) to exchange among those agencies and Indian health programs information relating to prescription drug abuse in Indian communities, including statutory and administrative requirements and limitations relating to that abuse; and

(B) training for Indian health care providers, tribal leaders, law enforcement officers, and school officials regarding awareness and prevention of prescription drug abuse and strategies for improving agency responses to addressing prescription drug abuse in Indian communities.

(2) **REPORT.**—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Attorney General shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes—

(A) the capacity of Federal and tribal agencies to carry out data collection and analysis and information exchanges as described in paragraph (1)(A);

(B) the training conducted pursuant to paragraph (1)(B);

(C) infrastructure enhancements required to carry out the activities described in paragraph (1), if any; and

(D) any statutory or administrative barriers to carrying out those activities.

SEC. 828. [25 U.S.C. 1680r] TRIBAL HEALTH PROGRAM OPTION FOR COST SHARING.

(a) **IN GENERAL.**—Nothing in this Act limits the ability of a tribal health program operating any health program, service, function, activity, or facility funded, in whole or part, by the Service through, or provided for in, a compact with the Service pursuant to title V of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 458aaa et seq.) to charge an Indian for services provided by the tribal health program.

(b) **SERVICE.**—Nothing in this Act authorizes the Service—

(1) to charge an Indian for services; or

(2) to require any tribal health program to charge an Indian for services.

SEC. 829. [25 U.S.C. 1680s] DISEASE AND INJURY PREVENTION REPORT.

Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committees on Natural Resources and Energy and Commerce of the House of Representatives describing—

(1) all disease and injury prevention activities conducted by the Service, independently or in conjunction with other Federal departments and agencies and Indian tribes; and

(2) the effectiveness of those activities, including the reductions of injury or disease conditions achieved by the activities.

SEC. 830. [25 U.S.C. 1680t] OTHER GAO REPORTS.

(a) **COORDINATION OF SERVICES.**—

(1) **STUDY AND EVALUATION.**—The Comptroller General of the United States shall conduct a study, and evaluate the effectiveness, of coordination of health care services provided to Indians—

(A) through Medicare, Medicaid, or SCHIP;

(B) by the Service; or

(C) using funds provided by—

(i) State or local governments; or

(ii) Indian tribes.

(2) **REPORT.**—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report—

(A) describing the results of the evaluation under paragraph (1); and

(B) containing recommendations of the Comptroller General regarding measures to support and increase co-

ordination of the provision of health care services to Indians as described in paragraph (1).

(b) PAYMENTS FOR CONTRACT HEALTH SERVICES.—

(1) IN GENERAL.—The Comptroller General shall conduct a study on the use of health care furnished by health care providers under the contract health services program funded by the Service and operated by the Service, an Indian tribe, or a tribal organization.

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

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

(B) barriers to accessing care under such contract health services program, including barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under the program;

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

(D) the administration of the contract health service program, including the distribution of funds to Indian health programs pursuant to the program; and

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

(3) REPORT.—Not later than 18 months after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations regarding—

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

(B) how to most efficiently use that funding; and

(C) the identification of any inequities in the current distribution formula or inequitable results for any Indian tribe under the funding level, and any recommendations for addressing any inequities or inequitable results identified.

(4) CONSULTATION.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Comptroller General shall consult with the Service, Indian tribes, and tribal organizations.

SEC. 831. [25 U.S.C. 1680u] TRADITIONAL HEALTH CARE PRACTICES.

Although the Secretary may promote traditional health care practices, consistent with the Service standards for the provision of health care, health promotion, and disease prevention under this Act, the United States is not liable for any provision of traditional health care practices pursuant to this Act that results in damage,

injury, or death to a patient. Nothing in this subsection shall be construed to alter any liability or other obligation that the United States may otherwise have under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or this Act.

SEC. 832. [25 U.S.C. 1680v] DIRECTOR OF HIV/AIDS PREVENTION AND TREATMENT.

(a) **ESTABLISHMENT.**—The Secretary, acting through the Service, shall establish within the Service the position of the Director of HIV/AIDS Prevention and Treatment (referred to in this section as the “Director”).

(b) **DUTIES.**—The Director shall—

(1) coordinate and promote HIV/AIDS prevention and treatment activities specific to Indians;

(2) provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations regarding existing HIV/AIDS prevention and treatment programs; and

(3) ensure interagency coordination to facilitate the inclusion of Indians in Federal HIV/AIDS research and grant opportunities, with emphasis on the programs operated under the Ryan White Comprehensive Aids Resources Emergency Act of 1990 (Public Law 101–381; 104 Stat. 576) and the amendments made by that Act.

(c) **REPORT.**—Not later than 2 years after the date of enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, and not less frequently than once every 2 years thereafter, the Director shall submit to Congress a report describing, with respect to the preceding 2-year period—

(1) each activity carried out under this section; and

(2) any findings of the Director with respect to HIV/AIDS prevention and treatment activities specific to Indians.