

AMENDMENT NO. _____ Calendar No. _____

Purpose: To revise and extend the Indian Health Care Improvement Act.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

To amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Referred to the Committee on _____ and
ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by _____

Viz:

1 At the end, add the following:

2 **DIVISION B—INDIAN HEALTH**
3 **CARE IMPROVEMENT ACT RE-**
4 **AUTHORIZATION AND EXTEN-**
5 **SION**

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

7 (a) SHORT TITLE.—This Act may be cited as the
8 “Indian Health Care Improvement Reauthorization and
9 Extension Act of 2009”.

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

Sec. 1. Short title; table of contents.

TITLE I—INDIAN HEALTH CARE IMPROVEMENT ACT
REAUTHORIZATION AND AMENDMENTS

Sec. 101. Reauthorization.

Sec. 102. Findings.

Sec. 103. Declaration of national Indian health policy.

Sec. 104. Definitions.

Subtitle A—Indian Health Manpower

Sec. 111. Community Health Aide Program.

Sec. 112. Health professional chronic shortage demonstration programs.

Sec. 113. Exemption from payment of certain fees.

Subtitle B—Health Services

Sec. 121. Indian Health Care Improvement Fund.

Sec. 122. Catastrophic Health Emergency Fund.

Sec. 123. Diabetes prevention, treatment, and control.

Sec. 124. Other authority for provision of services; shared services for long-term care.

Sec. 125. Reimbursement from certain third parties of costs of health services.

Sec. 126. Crediting of reimbursements.

Sec. 127. Behavioral health training and community education programs.

Sec. 128. Cancer screenings.

Sec. 129. Patient travel costs.

Sec. 130. Epidemiology centers.

Sec. 131. Indian youth grant program.

Sec. 132. American Indians Into Psychology Program.

Sec. 133. Prevention, control, and elimination of communicable and infectious diseases.

Sec. 134. Methods to increase clinician recruitment and retention issues.

Sec. 135. Liability for payment.

Sec. 136. Offices of Indian Men's Health and Indian Women's Health.

Sec. 137. Contract health service administration and disbursement formula.

Subtitle C—Health Facilities

Sec. 141. Health care facility priority system.

Sec. 142. Indian health care delivery demonstration projects.

Sec. 143. Tribal management of federally owned quarters.

Sec. 144. Other funding, equipment, and supplies for facilities.

Sec. 145. Indian country modular component facilities demonstration program.

Sec. 146. Mobile health stations demonstration program.

Subtitle D—Access to Health Services

Sec. 151. Treatment of payments under Social Security Act health benefits programs.

Sec. 152. Purchasing health care coverage.

3

- Sec. 153. Grants to and contracts with the Service, Indian tribes, tribal organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs.
- Sec. 154. Sharing arrangements with Federal agencies.
- Sec. 155. Eligible Indian veteran services.
- Sec. 156. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services.
- Sec. 157. Access to Federal insurance.
- Sec. 158. General exceptions.
- Sec. 159. Navajo Nation Medicaid Agency feasibility study.

Subtitle E—Health Services for Urban Indians

- Sec. 161. Facilities renovation.
- Sec. 162. Treatment of certain demonstration projects.
- Sec. 163. Requirement to confer with urban Indian organizations.
- Sec. 164. Expanded program authority for urban Indian organizations.
- Sec. 165. Community health representatives.
- Sec. 166. Use of Federal Government facilities and sources of supply; health information technology.

Subtitle F—Organizational Improvements

- Sec. 171. Establishment of the Indian Health Service as an agency of the Public Health Service.
- Sec. 172. Office of Direct Service Tribes.
- Sec. 173. Nevada area office.

Subtitle G—Behavioral Health Programs

- Sec. 181. Behavioral health programs.

Subtitle H—Miscellaneous

- Sec. 191. Confidentiality of medical quality assurance records; qualified immunity for participants.
- Sec. 192. Arizona, North Dakota, and South Dakota as contract health service delivery areas; eligibility of California Indians.
- Sec. 193. Methods to increase access to professionals of certain corps.
- Sec. 194. Health services for ineligible persons.
- Sec. 195. Annual budget submission.
- Sec. 196. Prescription drug monitoring.
- Sec. 197. Tribal health program option for cost sharing.
- Sec. 198. Disease and injury prevention report.
- Sec. 199. Other GAO reports.
- Sec. 199A. Traditional health care practices.
- Sec. 199B. Director of HIV/AIDS Prevention and Treatment.

TITLE II—AMENDMENTS TO OTHER ACTS

- Sec. 201. Medicare amendments.
- Sec. 202. Reauthorization of Native Hawaiian health care programs.

1 **TITLE I—INDIAN HEALTH CARE**
2 **IMPROVEMENT ACT REAU-**
3 **THORIZATION AND AMEND-**
4 **MENTS**

5 **SEC. 101. REAUTHORIZATION.**

6 (a) IN GENERAL.—Section 825 of the Indian Health
7 Care Improvement Act (25 U.S.C. 1680o) is amended to
8 read as follows:

9 **“SEC. 825. AUTHORIZATION OF APPROPRIATIONS.**

10 “There are authorized to be appropriated such sums
11 as are necessary to carry out this Act for fiscal year 2010
12 and each fiscal year thereafter, to remain available until
13 expended.”.

14 (b) REPEALS.—The following provisions of the In-
15 dian Health Care Improvement Act are repealed:

16 (1) Section 123 (25 U.S.C. 1616p).

17 (2) Paragraph (6) of section 209(m) (25 U.S.C.
18 1621h(m)).

19 (3) Subsection (g) of section 211 (25 U.S.C.
20 1621j).

21 (4) Subsection (e) of section 216 (25 U.S.C.
22 1621o).

23 (5) Section 224 (25 U.S.C. 1621w).

24 (6) Section 309 (25 U.S.C. 1638a).

25 (7) Section 407 (25 U.S.C. 1647).

1 (8) Subsection (c) of section 512 (25 U.S.C.
2 1660b).

3 (9) Section 514 (25 U.S.C. 1660d).

4 (10) Section 603 (25 U.S.C. 1663).

5 (11) Section 805 (25 U.S.C. 1675).

6 (c) CONFORMING AMENDMENTS.—

7 (1) Section 204(c)(1) of the Indian Health Care
8 Improvement Act (25 U.S.C. 1621c(c)(1)) is amend-
9 ed by striking “through fiscal year 2000”.

10 (2) Section 213 of the Indian Health Care Im-
11 provement Act (25 U.S.C. 1621*l*) is amended by
12 striking “(a) The Secretary” and inserting “The
13 Secretary”.

14 (3) Section 310 of the Indian Health Care Im-
15 provement Act (25 U.S.C. 1638b) is amended by
16 striking “funds provided pursuant to the authoriza-
17 tion contained in section 309” each place it appears
18 and inserting “funds made available to carry out
19 this title”.

20 **SEC. 102. FINDINGS.**

21 Section 2 of the Indian Health Care Improvement
22 Act (25 U.S.C. 1601) is amended—

23 (1) by redesignating subsections (a), (b), (c),
24 and (d) as paragraphs (1), (3), (4), and (5), respec-

1 tively, and indenting the paragraphs appropriately;
2 and

3 (2) by inserting after paragraph (1) (as so re-
4 designated) the following:

5 “(2) A major national goal of the United States
6 is to provide the resources, processes, and structure
7 that will enable Indian tribes and tribal members to
8 obtain the quantity and quality of health care serv-
9 ices and opportunities that will eradicate the health
10 disparities between Indians and the general popu-
11 lation of the United States.”.

12 **SEC. 103. DECLARATION OF NATIONAL INDIAN HEALTH**
13 **POLICY.**

14 Section 3 of the Indian Health Care Improvement
15 Act (25 U.S.C. 1602) is amended to read as follows:

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

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

21 “(1) to ensure the highest possible health status
22 for Indians and urban Indians and to provide all re-
23 sources necessary to effect that policy;

24 “(2) to raise the health status of Indians and
25 urban Indians to at least the levels set forth in the

1 goals contained within the Healthy People 2010 ini-
2 tiative or successor objectives;

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

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

14 “(5) to require that all actions under this Act
15 shall be carried out with active and meaningful con-
16 sultation with Indian tribes and tribal organizations,
17 and conference with urban Indian organizations, to
18 implement this Act and the national policy of Indian
19 self-determination;

20 “(6) to ensure that the United States and In-
21 dian tribes work in a government-to-government re-
22 lationship to ensure quality health care for all tribal
23 members; and

24 “(7) to provide funding for programs and facili-
25 ties operated by Indian tribes and tribal organiza-

1 tions in amounts that are not less than the amounts
2 provided to programs and facilities operated directly
3 by the Service.”.

4 **SEC. 104. DEFINITIONS.**

5 Section 4 of the Indian Health Care Improvement
6 Act (25 U.S.C. 1603) is amended—

7 (1) by striking the matter preceding subsection
8 (a) and inserting “In this Act.”;

9 (2) in each of subsections (c), (j), (k), and (l),
10 by redesignating the paragraphs contained in the
11 subsections as subparagraphs and indenting the sub-
12 paragraphs appropriately;

13 (3) by redesignating subsections (a) through (q)
14 as paragraphs (17), (18), (13), (14), (26), (28),
15 (27), (29), (1), (20), (11), (7), (19), (10), (21), (8),
16 and (9), respectively, indenting the paragraphs ap-
17 propriately, and moving the paragraphs so as to ap-
18 pear in numerical order;

19 (4) in each paragraph (as so redesignated), by
20 inserting a heading the text of which is comprised of
21 the term defined in the paragraph;

22 (5) by inserting “The term” after each para-
23 graph heading;

24 (6) by inserting after paragraph (1) (as redesi-
25 gnated by paragraph (3)) the following:

1 “(2) BEHAVIORAL HEALTH.—

2 “(A) IN GENERAL.—The term ‘behavioral
3 health’ means the blending of substance (alco-
4 hol, drugs, inhalants, and tobacco) abuse and
5 mental health disorders prevention and treat-
6 ment for the purpose of providing comprehen-
7 sive services.

8 “(B) INCLUSIONS.—The term ‘behavioral
9 health’ includes the joint development of sub-
10 stance abuse and mental health treatment plan-
11 ning and coordinated case management using a
12 multidisciplinary approach.

13 “(3) CALIFORNIA INDIAN.—The term ‘Cali-
14 fornia Indian’ means any Indian who is eligible for
15 health services provided by the Service pursuant to
16 section 809.

17 “(4) COMMUNITY COLLEGE.—The term ‘com-
18 munity college’ means—

19 “(A) a tribal college or university; or

20 “(B) a junior or community college.

21 “(5) CONTRACT HEALTH SERVICE.—The term
22 ‘contract health service’ means any health service
23 that is—

24 “(A) delivered based on a referral by, or at
25 the expense of, an Indian health program; and

1 “(B) provided by a public or private med-
2 ical provider or hospital that is not a provider
3 or hospital of the Indian health program.

4 “(6) DEPARTMENT.—The term ‘Department’,
5 unless otherwise designated, means the Department
6 of Health and Human Services.”;

7 (7) by striking paragraph (7) (as redesignated
8 by paragraph (3)) and inserting the following:

9 “(7) DISEASE PREVENTION.—

10 “(A) IN GENERAL.—The term ‘disease pre-
11 vention’ means any activity for—

12 “(i) the reduction, limitation, and pre-
13 vention of—

14 “(I) disease; and

15 “(II) complications of disease;

16 and

17 “(ii) the reduction of consequences of
18 disease.

19 “(B) INCLUSIONS.—The term ‘disease pre-
20 vention’ includes an activity for—

21 “(i) controlling—

22 “(I) the development of diabetes;

23 “(II) high blood pressure;

24 “(III) infectious agents;

25 “(IV) injuries;

11

1 “(V) occupational hazards and
2 disabilities;

3 “(VI) sexually transmittable dis-
4 eases; or

5 “(VII) toxic agents; or

6 “(ii) providing—

7 “(I) fluoridation of water; or

8 “(II) immunizations.”;

9 (8) by striking paragraph (9) (as redesignated
10 by paragraph (3)) and inserting the following:

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

15 “(A) Central nervous system involvement
16 such as mental retardation, developmental
17 delay, intellectual deficit, microencephaly, or
18 neurologic abnormalities.

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

24 “(C) Prenatal or postnatal growth delay.”;

1 (9) by striking paragraphs (11) and (12) (as
2 redesignated by paragraph (3)) and inserting the
3 following:

4 “(11) HEALTH PROMOTION.—The term ‘health
5 promotion’ means any activity for—

6 “(A) fostering social, economic, environ-
7 mental, and personal factors conducive to
8 health, including raising public awareness re-
9 garding health matters and enabling individuals
10 to cope with health problems by increasing
11 knowledge and providing valid information;

12 “(B) encouraging adequate and appro-
13 priate diet, exercise, and sleep;

14 “(C) promoting education and work in ac-
15 cordance with physical and mental capacity;

16 “(D) making available safe water and sani-
17 tary facilities;

18 “(E) improving the physical, economic, cul-
19 tural, psychological, and social environment;

20 “(F) promoting culturally competent care;
21 and

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

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

- 1 “(ii) community health;
- 2 “(iii) community safety;
- 3 “(iv) consumer health education;
- 4 “(v) diet and nutrition;
- 5 “(vi) immunization and other methods
- 6 of prevention of communicable diseases, in-
- 7 cluding HIV/AIDS;
- 8 “(vii) environmental health;
- 9 “(viii) exercise and physical fitness;
- 10 “(ix) avoidance of fetal alcohol spec-
- 11 trum disorders;
- 12 “(x) first aid and CPR education;
- 13 “(xi) human growth and development;
- 14 “(xii) injury prevention and personal
- 15 safety;
- 16 “(xiii) behavioral health;
- 17 “(xiv) monitoring of disease indicators
- 18 between health care provider visits through
- 19 appropriate means, including Internet-
- 20 based health care management systems;
- 21 “(xv) personal health and wellness
- 22 practices;
- 23 “(xvi) personal capacity building;
- 24 “(xvii) prenatal, pregnancy, and in-
- 25 fant care;

1 “(xviii) psychological well-being;
2 “(xix) reproductive health and family
3 planning;
4 “(xx) safe and adequate water;
5 “(xxi) healthy work environments;
6 “(xxii) elimination, reduction, and
7 prevention of contaminants that create
8 unhealthy household conditions (including
9 mold and other allergens);
10 “(xxiii) stress control;
11 “(xxiv) substance abuse;
12 “(xxv) sanitary facilities;
13 “(xxvi) sudden infant death syndrome
14 prevention;
15 “(xxvii) tobacco use cessation and re-
16 duction;
17 “(xxviii) violence prevention; and
18 “(xxix) such other activities identified
19 by the Service, a tribal health program, or
20 an urban Indian organization to promote
21 achievement of any of the objectives re-
22 ferred to in section 3(2).

23 “(12) INDIAN HEALTH PROGRAM.—The term
24 ‘Indian health program’ means—

1 Claims Settlement Act (43 U.S.C. 1601 et
2 seq.).”;

3 (11) by striking paragraph (20) (as redesignig-
4 nated by paragraph (3)) and inserting the following:

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

10 (12) by inserting after paragraph (21) (as re-
11 designated by paragraph (3)) the following:

12 “(22) TELEHEALTH.—The term ‘telehealth’ has
13 the meaning given the term in section 330K(a) of
14 the Public Health Service Act (42 U.S.C. 254c–
15 16(a)).

16 “(23) TELEMEDICINE.—The term ‘telemedicine’
17 means a telecommunications link to an end user
18 through the use of eligible equipment that electroni-
19 cally links health professionals or patients and
20 health professionals at separate sites in order to ex-
21 change health care information in audio, video,
22 graphic, or other format for the purpose of providing
23 improved health care services.

24 “(24) TRIBAL COLLEGE OR UNIVERSITY.—The
25 term ‘tribal college or university’ has the meaning

1 given the term in section 316(b) of the Higher Edu-
2 cation Act of 1965 (20 U.S.C. 1059c(b)).

3 “(25) TRIBAL HEALTH PROGRAM.—The term
4 ‘tribal health program’ means an Indian tribe or
5 tribal organization that operates any health pro-
6 gram, service, function, activity, or facility funded,
7 in whole or part, by the Service through, or provided
8 for in, a contract or compact with the Service under
9 the Indian Self-Determination and Education Assist-
10 ance Act (25 U.S.C. 450 et seq.)”; and

11 (13) by striking paragraph (26) (as redesign-
12 nated by paragraph (3)) and inserting the following:

13 “(26) TRIBAL ORGANIZATION.—The term ‘trib-
14 al organization’ has the meaning given the term in
15 section 4 of the Indian Self-Determination and Edu-
16 cation Assistance Act (25 U.S.C. 450b).”.

17 **Subtitle A—Indian Health**
18 **Manpower**

19 **SEC. 111. COMMUNITY HEALTH AIDE PROGRAM.**

20 Section 119 of the Indian Health Care Improvement
21 Act (25 U.S.C. 1616*l*) is amended to read as follows:

22 **“SEC. 119. COMMUNITY HEALTH AIDE PROGRAM.**

23 “(a) GENERAL PURPOSES OF PROGRAM.—Pursuant
24 to the Act of November 2, 1921 (25 U.S.C. 13) (commonly
25 known as the ‘Snyder Act’), the Secretary, acting through

1 the Service, shall develop and operate a Community
2 Health Aide Program in the State of Alaska under which
3 the Service—

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

6 “(2) uses those aides or practitioners in the
7 provision of health care, health promotion, and dis-
8 ease prevention services to Alaska Natives living in
9 villages in rural Alaska; and

10 “(3) provides for the establishment of tele-
11 conferencing capacity in health clinics located in or
12 near those villages for use by community health
13 aides or community health practitioners.

14 “(b) SPECIFIC PROGRAM REQUIREMENTS.—The Sec-
15 retary, acting through the Community Health Aide Pro-
16 gram of the Service, shall—

17 “(1) using trainers accredited by the Program,
18 provide a high standard of training to community
19 health aides and community health practitioners to
20 ensure that those aides and practitioners provide
21 quality health care, health promotion, and disease
22 prevention services to the villages served by the Pro-
23 gram;

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

1 “(A) combines education regarding the
2 theory of health care with supervised practical
3 experience in the provision of health care;

4 “(B) provides instruction and practical ex-
5 perience in the provision of acute care, emer-
6 gency care, health promotion, disease preven-
7 tion, and the efficient and effective manage-
8 ment of clinic pharmacies, supplies, equipment,
9 and facilities; and

10 “(C) promotes the achievement of the
11 health status objectives specified in section
12 3(2);

13 “(3) establish and maintain a Community
14 Health Aide Certification Board to certify as com-
15 munity health aides or community health practi-
16 tioners individuals who have successfully completed
17 the training described in paragraph (1) or can dem-
18 onstrate equivalent experience;

19 “(4) develop and maintain a system that identi-
20 fies the needs of community health aides and com-
21 munity health practitioners for continuing education
22 in the provision of health care, including the areas
23 described in paragraph (2)(B), and develop pro-
24 grams that meet the needs for such continuing edu-
25 cation;

1 “(5) develop and maintain a system that pro-
2 vides close supervision of community health aides
3 and community health practitioners;

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

9 “(7) ensure that—

10 “(A) pulpal therapy (not including
11 pulpotomies on deciduous teeth) or extraction of
12 adult teeth can be performed by a dental health
13 aide therapist only after consultation with a li-
14 censed dentist who determines that the proce-
15 dure is a medical emergency that cannot be re-
16 solved with palliative treatment; and

17 “(B) dental health aide therapists are
18 strictly prohibited from performing all other
19 oral or jaw surgeries, subject to the condition
20 that uncomplicated extractions shall not be con-
21 sidered oral surgery under this section.

22 “(c) PROGRAM REVIEW.—

23 “(1) NEUTRAL PANEL.—

24 “(A) ESTABLISHMENT.—The Secretary,
25 acting through the Service, shall establish a

1 neutral panel to carry out the study under
2 paragraph (2).

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

8 “(2) STUDY.—

9 “(A) IN GENERAL.—The neutral panel es-
10 tablished under paragraph (1) shall conduct a
11 study of the dental health aide therapist serv-
12 ices provided by the Community Health Aide
13 Program under this section to ensure that the
14 quality of care provided through those services
15 is adequate and appropriate.

16 “(B) PARAMETERS OF STUDY.—The Sec-
17 retary, in consultation with interested parties,
18 including professional dental organizations,
19 shall develop the parameters of the study.

20 “(C) INCLUSIONS.—The study shall in-
21 clude a determination by the neutral panel with
22 respect to—

23 “(i) the ability of the dental health
24 aide therapist services under this section to

1 address the dental care needs of Alaska
2 Natives;

3 “(ii) the quality of care provided
4 through those services, including any train-
5 ing, improvement, or additional oversight
6 required to improve the quality of care;
7 and

8 “(iii) whether safer and less costly al-
9 ternatives to the dental health aide thera-
10 pist services exist.

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

16 “(3) REPORT.—The neutral panel shall submit
17 to the Secretary, the Committee on Indian Affairs of
18 the Senate, and the Committee on Natural Re-
19 sources of the House of Representatives a report de-
20 scribing the results of the study under paragraph
21 (2), including a description of—

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

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

1 “(d) NATIONALIZATION OF PROGRAM.—

2 “(1) IN GENERAL.—Except as provided in para-
3 graph (2), the Secretary, acting through the Service,
4 may establish a national Community Health Aide
5 Program in accordance with the program under this
6 section, as the Secretary determines to be appro-
7 priate.

8 “(2) REQUIREMENT; EXCLUSION.—In estab-
9 lishing a national program under paragraph (1), the
10 Secretary—

11 “(A) shall not reduce the amounts pro-
12 vided for the Community Health Aide Program
13 described in subsections (a) and (b); and

14 “(B) shall exclude dental health aide thera-
15 pist services from services covered under the
16 program.”.

17 **SEC. 112. HEALTH PROFESSIONAL CHRONIC SHORTAGE**
18 **DEMONSTRATION PROGRAMS.**

19 Title I of the Indian Health Care Improvement Act
20 (25 U.S.C. 1611 et seq.) (as amended by section 101(b))
21 is amended by adding at the end the following:

22 **“SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE**
23 **DEMONSTRATION PROGRAMS.**

24 “(a) DEMONSTRATION PROGRAMS.—The Secretary,
25 acting through the Service, may fund demonstration pro-

1 grams for Indian health programs to address the chronic
2 shortages of health professionals.

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

5 “(1) to provide direct clinical and practical ex-
6 perience within an Indian health program to health
7 profession students and residents from medical
8 schools;

9 “(2) to improve the quality of health care for
10 Indians by ensuring access to qualified health pro-
11 fessionals;

12 “(3) to provide academic and scholarly opportu-
13 nities for health professionals serving Indians by
14 identifying all academic and scholarly resources of
15 the region; and

16 “(4) to provide training and support for alter-
17 native provider types, such as community health rep-
18 resentatives, and community health aides.

19 “(c) ADVISORY BOARD.—The demonstration pro-
20 grams established pursuant to subsection (a) shall incor-
21 porate a program advisory board, which may be composed
22 of representatives of tribal governments, Indian health
23 programs, and Indian communities in the areas to be
24 served by the demonstration programs.”.

1 **SEC. 113. EXEMPTION FROM PAYMENT OF CERTAIN FEES.**

2 Title I of the Indian Health Care Improvement Act
3 (25 U.S.C. 1611 et seq.) (as amended by section 112) is
4 amended by adding at the end the following:

5 **“SEC. 124. EXEMPTION FROM PAYMENT OF CERTAIN FEES.**

6 “Employees of a tribal health program or urban In-
7 dian organization shall be exempt from payment of licens-
8 ing, registration, and any other fees imposed by a Federal
9 agency to the same extent that officers of the commis-
10 sioned corps of the Public Health Service and other em-
11 ployees of the Service are exempt from those fees.”.

12 **Subtitle B—Health Services**

13 **SEC. 121. INDIAN HEALTH CARE IMPROVEMENT FUND.**

14 Section 201 of the Indian Health Care Improvement
15 Act (25 U.S.C. 1621) is amended to read as follows:

16 **“SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.**

17 “(a) USE OF FUNDS.—The Secretary, acting through
18 the Service, is authorized to expend funds, directly or
19 under the authority of the Indian Self-Determination and
20 Education Assistance Act (25 U.S.C. 450 et seq.), which
21 are appropriated under the authority of this section, for
22 the purposes of—

23 “(1) eliminating the deficiencies in health sta-
24 tus and health resources of all Indian tribes;

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

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

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

7 “(5) augmenting the ability of the Service to
8 meet the following health service responsibilities with
9 respect to those Indian tribes with the highest levels
10 of health status deficiencies and resource defi-
11 ciencies:

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

16 “(B) Preventive health, including mam-
17 mography and other cancer screening.

18 “(C) Dental care.

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

25 “(E) Emergency medical services.

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

5 “(G) Injury prevention programs, includ-
6 ing data collection and evaluation, demonstra-
7 tion projects, training, and capacity building.

8 “(H) Home health care.

9 “(I) Community health representatives.

10 “(J) Maintenance and improvement.

11 “(b) NO OFFSET OR LIMITATION.—Any funds appro-
12 priated under the authority of this section shall not be
13 used to offset or limit any other appropriations made to
14 the Service under this Act or the Act of November 2, 1921
15 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’),
16 or any other provision of law.

17 “(c) ALLOCATION; USE.—

18 “(1) IN GENERAL.—Funds appropriated under
19 the authority of this section shall be allocated to
20 Service units, Indian tribes, or tribal organizations.
21 The funds allocated to each Indian tribe, tribal orga-
22 nization, or Service unit under this paragraph shall
23 be used by the Indian tribe, tribal organization, or
24 Service unit under this paragraph to improve the
25 health status and reduce the resource deficiency of

1 each Indian tribe served by such Service unit, Indian
2 tribe, or tribal organization.

3 “(2) APPORTIONMENT OF ALLOCATED
4 FUNDS.—The apportionment of funds allocated to a
5 Service unit, Indian tribe, or tribal organization
6 under paragraph (1) among the health service re-
7 sponsibilities described in subsection (a)(5) shall be
8 determined by the Service in consultation with, and
9 with the active participation of, the affected Indian
10 tribes and tribal organizations.

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

14 “(1) DEFINITION.—The term ‘health status
15 and resource deficiency’ means the extent to
16 which—

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

20 “(B) the Indian tribe or tribal organization
21 does not have available to it the health re-
22 sources it needs, taking into account the actual
23 cost of providing health care services given local
24 geographic, climatic, rural, or other cir-
25 cumstances.

1 “(2) AVAILABLE RESOURCES.—The health re-
2 sources available to an Indian tribe or tribal organi-
3 zation include health resources provided by the Serv-
4 ice as well as health resources used by the Indian
5 tribe or tribal organization, including services and fi-
6 nancing systems provided by any Federal programs,
7 private insurance, and programs of State or local
8 governments.

9 “(3) PROCESS FOR REVIEW OF DETERMINA-
10 TIONS.—The Secretary shall establish procedures
11 which allow any Indian tribe or tribal organization
12 to petition the Secretary for a review of any deter-
13 mination of the extent of the health status and re-
14 source deficiency of such Indian tribe or tribal orga-
15 nization.

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

20 “(f) REPORT.—By no later than the date that is 3
21 years after the date of enactment of the Indian Health
22 Care Improvement Reauthorization and Extension Act of
23 2009, the Secretary shall submit to Congress the current
24 health status and resource deficiency report of the Service

1 for each Service unit, including newly recognized or ac-
2 knowledged Indian tribes. Such report shall set out—

3 “(1) the methodology then in use by the Service
4 for determining tribal health status and resource de-
5 ficiencies, as well as the most recent application of
6 that methodology;

7 “(2) the extent of the health status and re-
8 source deficiency of each Indian tribe served by the
9 Service or a tribal health program;

10 “(3) the amount of funds necessary to eliminate
11 the health status and resource deficiencies of all In-
12 dian tribes served by the Service or a tribal health
13 program; and

14 “(4) an estimate of—

15 “(A) the amount of health service funds
16 appropriated under the authority of this Act, or
17 any other Act, including the amount of any
18 funds transferred to the Service for the pre-
19 ceding fiscal year which is allocated to each
20 Service unit, Indian tribe, or tribal organiza-
21 tion;

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

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

7 “(g) INCLUSION IN BASE BUDGET.—Funds appro-
8 priated under this section for any fiscal year shall be in-
9 cluded in the base budget of the Service for the purpose
10 of determining appropriations under this section in subse-
11 quent fiscal years.

12 “(h) CLARIFICATION.—Nothing in this section is in-
13 tended to diminish the primary responsibility of the Serv-
14 ice to eliminate existing backlogs in unmet health care
15 needs, nor are the provisions of this section intended to
16 discourage the Service from undertaking additional efforts
17 to achieve equity among Indian tribes and tribal organiza-
18 tions.

19 “(i) FUNDING DESIGNATION.—Any funds appro-
20 priated under the authority of this section shall be des-
21 ignated as the ‘Indian Health Care Improvement Fund’.”.

22 **SEC. 122. CATASTROPHIC HEALTH EMERGENCY FUND.**

23 Section 202 of the Indian Health Care Improvement
24 Act (25 U.S.C. 1621a) is amended to read as follows:

1 **“SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.**

2 “(a) ESTABLISHMENT.—There is established an In-
3 dian Catastrophic Health Emergency Fund (hereafter in
4 this section referred to as the ‘CHEF’) consisting of—

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

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

9 “(b) ADMINISTRATION.—CHEF’ shall be adminis-
10 tered by the Secretary, acting through the headquarters
11 of the Service, solely for the purpose of meeting the ex-
12 traordinary medical costs associated with the treatment of
13 victims of disasters or catastrophic illnesses who are with-
14 in the responsibility of the Service.

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

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

25 “(1) establish a definition of disasters and cata-
26 strophic illnesses for which the cost of the treatment

1 provided under contract would qualify for payment
2 from CHEF;

3 “(2) provide that a Service Unit shall not be el-
4 ible for reimbursement for the cost of treatment
5 from CHEF until its cost of treating any victim of
6 such catastrophic illness or disaster has reached a
7 certain threshold cost which the Secretary shall es-
8 tablish at—

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

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

17 “(3) establish a procedure for the reimburse-
18 ment of the portion of the costs that exceeds such
19 threshold cost incurred by—

20 “(A) Service Units; or

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

23 “(4) establish a procedure for payment from
24 CHEF in cases in which the exigencies of the med-

1 ical circumstances warrant treatment prior to the
2 authorization of such treatment by the Service; and

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

9 “(e) NO OFFSET OR LIMITATION.—Amounts appro-
10 priated to CHEF under this section shall not be used to
11 offset or limit appropriations made to the Service under
12 the authority of the Act of November 2, 1921 (25 U.S.C.
13 13) (commonly known as the ‘Snyder Act’), or any other
14 law.

15 “(f) DEPOSIT OF REIMBURSEMENT FUNDS.—There
16 shall be deposited into CHEF all reimbursements to which
17 the Service is entitled from any Federal, State, local, or
18 private source (including third party insurance) by reason
19 of treatment rendered to any victim of a disaster or cata-
20 strophic illness the cost of which was paid from CHEF.”.

21 **SEC. 123. DIABETES PREVENTION, TREATMENT, AND CON-**
22 **TROL.**

23 Section 204 of the Indian Health Care Improvement
24 Act (25 U.S.C. 1621c) is amended to read as follows:

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

3 “(a) DETERMINATIONS REGARDING DIABETES.—
4 The Secretary, acting through the Service, and in con-
5 sultation with Indian tribes and tribal organizations, shall
6 determine—

7 “(1) by Indian tribe and by Service unit, the in-
8 cidence of, and the types of complications resulting
9 from, diabetes among Indians; and

10 “(2) based on the determinations made pursu-
11 ant to paragraph (1), the measures (including pa-
12 tient education and effective ongoing monitoring of
13 disease indicators) each Service unit should take to
14 reduce the incidence of, and prevent, treat, and con-
15 trol the complications resulting from, diabetes
16 among Indian tribes within that Service unit.

17 “(b) DIABETES SCREENING.—To the extent medi-
18 cally indicated and with informed consent, the Secretary
19 shall screen each Indian who receives services from the
20 Service for diabetes and for conditions which indicate a
21 high risk that the individual will become diabetic and es-
22 tablish a cost-effective approach to ensure ongoing moni-
23 toring of disease indicators. Such screening and moni-
24 toring may be conducted by a tribal health program and
25 may be conducted through appropriate Internet-based
26 health care management programs.

1 “(c) DIABETES PROJECTS.—The Secretary shall con-
2 tinue to maintain each model diabetes project in existence
3 on the date of enactment of the Indian Health Care Im-
4 provement Reauthorization and Extension Act of 2009,
5 any such other diabetes programs operated by the Service
6 or tribal health programs, and any additional diabetes
7 projects, such as the Medical Vanguard program provided
8 for in title IV of Public Law 108–87, as implemented to
9 serve Indian tribes. tribal health programs shall receive
10 recurring funding for the diabetes projects that they oper-
11 ate pursuant to this section, both at the date of enactment
12 of the Indian Health Care Improvement Reauthorization
13 and Extension Act of 2009 and for projects which are
14 added and funded thereafter.

15 “(d) DIALYSIS PROGRAMS.—The Secretary is author-
16 ized to provide, through the Service, Indian tribes, and
17 tribal organizations, dialysis programs, including the pur-
18 chase of dialysis equipment and the provision of necessary
19 staffing.

20 “(e) OTHER DUTIES OF THE SECRETARY.—

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

23 “(A) in each area office, consult with In-
24 dian tribes and tribal organizations regarding

1 programs for the prevention, treatment, and
2 control of diabetes;

3 “(B) establish in each area office a reg-
4 istry of patients with diabetes to track the inci-
5 dence of diabetes and the complications from
6 diabetes in that area; and

7 “(C) ensure that data collected in each
8 area office regarding diabetes and related com-
9 plications among Indians are disseminated to
10 all other area offices, subject to applicable pa-
11 tient privacy laws.

12 “(2) DIABETES CONTROL OFFICERS.—

13 “(A) IN GENERAL.—The Secretary may es-
14 tablish and maintain in each area office a posi-
15 tion of diabetes control officer to coordinate and
16 manage any activity of that area office relating
17 to the prevention, treatment, or control of dia-
18 betes to assist the Secretary in carrying out a
19 program under this section or section 330C of
20 the Public Health Service Act (42 U.S.C. 254c-
21 3).

22 “(B) CERTAIN ACTIVITIES.—Any activity
23 carried out by a diabetes control officer under
24 subparagraph (A) that is the subject of a con-
25 tract or compact under the Indian Self-Deter-

1 mination and Education Assistance Act (25
2 U.S.C. 450 et seq.), and any funds made avail-
3 able to carry out such an activity, shall not be
4 divisible for purposes of that Act.”.

5 **SEC. 124. OTHER AUTHORITY FOR PROVISION OF SERV-**
6 **ICES; SHARED SERVICES FOR LONG-TERM**
7 **CARE.**

8 (a) OTHER AUTHORITY FOR PROVISION OF SERV-
9 ICES.—

10 (1) IN GENERAL.—Section 205 of the Indian
11 Health Care Improvement Act (25 U.S.C. 1621d) is
12 amended to read as follows:

13 **“SEC. 205. OTHER AUTHORITY FOR PROVISION OF SERV-**
14 **ICES.**

15 “(a) DEFINITIONS.—In this section:

16 “(1) ASSISTED LIVING SERVICE.—The term ‘as-
17 sisted living service’ means any service provided by
18 an assisted living facility (as defined in section
19 232(b) of the National Housing Act (12 U.S.C.
20 1715w(b))), except that such an assisted living facil-
21 ity—

22 “(A) shall not be required to obtain a li-
23 cense; but

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

1 “(2) HOME- AND COMMUNITY-BASED SERV-
2 ICE.—The term ‘home- and community-based serv-
3 ice’ means 1 or more of the services specified in
4 paragraphs (1) through (9) of section 1929(a) of the
5 Social Security Act (42 U.S.C. 1396t(a)) (whether
6 provided by the Service or by an Indian tribe or trib-
7 al organization pursuant to the Indian Self-Deter-
8 mination and Education Assistance Act (25 U.S.C.
9 450 et seq.)) that are or will be provided in accord-
10 ance with applicable standards.

11 “(3) HOSPICE CARE.—The term ‘hospice care’
12 means—

13 “(A) the items and services specified in
14 subparagraphs (A) through (H) of section
15 1861(dd)(1) of the Social Security Act (42
16 U.S.C. 1395x(dd)(1)); and

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

21 “(4) LONG-TERM CARE SERVICES.—The term
22 ‘long-term care services’ has the meaning given the
23 term ‘qualified long-term care services’ in section
24 7702B(c) of the Internal Revenue Code of 1986.

1 “(b) FUNDING AUTHORIZED.—The Secretary, acting
2 through the Service, Indian tribes, and tribal organiza-
3 tions, may provide funding under this Act to meet the ob-
4 jectives set forth in section 3 through health care-related
5 services and programs not otherwise described in this Act
6 for the following services:

7 “(1) Hospice care.

8 “(2) Assisted living services.

9 “(3) Long-term care services.

10 “(4) Home- and community-based services.

11 “(c) ELIGIBILITY.—The following individuals shall be
12 eligible to receive long-term care services under this sec-
13 tion:

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

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

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

23 “(d) AUTHORIZATION OF CONVENIENT CARE SERV-
24 ICES.—The Secretary, acting through the Service, Indian
25 tribes, and tribal organizations, may also provide funding

1 under this Act to meet the objectives set forth in section
2 3 for convenient care services programs pursuant to sec-
3 tion 307(c)(2)(A).”.

4 (2) REPEAL.—Section 821 of the Indian Health
5 Care Improvement Act (25 U.S.C. 1680k) is re-
6 pealed.

7 (b) SHARED SERVICES FOR LONG-TERM CARE.—Sec-
8 tion 822 of the Indian Health Care Improvement Act (25
9 U.S.C. 1680l) is amended to read as follows:

10 **“SEC. 822. SHARED SERVICES FOR LONG-TERM CARE.**

11 “(a) LONG-TERM CARE.—

12 “(1) IN GENERAL.—Notwithstanding any other
13 provision of law, the Secretary, acting through the
14 Service, is authorized to provide directly, or enter
15 into contracts or compacts under the Indian Self-De-
16 termination and Education Assistance Act (25
17 U.S.C. 450 et seq.) with Indian tribes or tribal orga-
18 nizations for, the delivery of long-term care (includ-
19 ing health care services associated with long-term
20 care) provided in a facility to Indians.

21 “(2) INCLUSIONS.—Each agreement under
22 paragraph (1) shall provide for the sharing of staff
23 or other services between the Service or a tribal
24 health program and a long-term care or related facil-
25 ity owned and operated (directly or through a con-

1 tract or compact under the Indian Self-Determina-
2 tion and Education Assistance Act (25 U.S.C. 450
3 et seq.)) by the Indian tribe or tribal organization.

4 “(b) CONTENTS OF AGREEMENTS.—An agreement
5 entered into pursuant to subsection (a)—

6 “(1) may, at the request of the Indian tribe or
7 tribal organization, delegate to the Indian tribe or
8 tribal organization such powers of supervision and
9 control over Service employees as the Secretary de-
10 termines to be necessary to carry out the purposes
11 of this section;

12 “(2) shall provide that expenses (including sala-
13 ries) relating to services that are shared between the
14 Service and the tribal health program be allocated
15 proportionately between the Service and the Indian
16 tribe or tribal organization; and

17 “(3) may authorize the Indian tribe or tribal
18 organization to construct, renovate, or expand a
19 long-term care or other similar facility (including the
20 construction of a facility attached to a Service facil-
21 ity).

22 “(c) MINIMUM REQUIREMENT.—Any nursing facility
23 provided for under this section shall meet the require-
24 ments for nursing facilities under section 1919 of the So-
25 cial Security Act (42 U.S.C. 1396r).

1 “(d) OTHER ASSISTANCE.—The Secretary shall pro-
2 vide such technical and other assistance as may be nec-
3 essary to enable applicants to comply with this section.

4 “(e) USE OF EXISTING OR UNDERUSED FACILI-
5 TIES.—The Secretary shall encourage the use of existing
6 facilities that are underused, or allow the use of swing
7 beds, for long-term or similar care.”.

8 **SEC. 125. REIMBURSEMENT FROM CERTAIN THIRD PAR-**
9 **TIES OF COSTS OF HEALTH SERVICES.**

10 Section 206 of the Indian Health Care Improvement
11 Act (25 U.S.C. 1621e) is amended to read as follows:

12 **“SEC. 206. REIMBURSEMENT FROM CERTAIN THIRD PAR-**
13 **TIES OF COSTS OF HEALTH SERVICES.**

14 “(a) RIGHT OF RECOVERY.—Except as provided in
15 subsection (f), the United States, an Indian tribe, or tribal
16 organization shall have the right to recover from an insur-
17 ance company, health maintenance organization, employee
18 benefit plan, third-party tortfeasor, or any other respon-
19 sible or liable third party (including a political subdivision
20 or local governmental entity of a State) the reasonable
21 charges billed by the Secretary, an Indian tribe, or tribal
22 organization in providing health services through the Serv-
23 ice, an Indian tribe, or tribal organization, or, if higher,
24 the highest amount the third party would pay for care and
25 services furnished by providers other than governmental

1 entities, to any individual to the same extent that such
2 individual, or any nongovernmental provider of such serv-
3 ices, would be eligible to receive damages, reimbursement,
4 or indemnification for such charges or expenses if—

5 “(1) such services had been provided by a non-
6 governmental provider; and

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

10 “(b) LIMITATIONS ON RECOVERIES FROM STATES.—

11 Subsection (a) shall provide a right of recovery against
12 any State, only if the injury, illness, or disability for which
13 health services were provided is covered under—

14 “(1) workers’ compensation laws; or

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

17 “(c) NONAPPLICABILITY OF OTHER LAWS.—No law

18 of any State, or of any political subdivision of a State and
19 no provision of any contract, insurance or health mainte-
20 nance organization policy, employee benefit plan, self-in-
21 surance plan, managed care plan, or other health care plan
22 or program entered into or renewed after the date of en-
23 actment of the Indian Health Care Amendments of 1988,
24 shall prevent or hinder the right of recovery of the United

1 States, an Indian tribe, or tribal organization under sub-
2 section (a).

3 “(d) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—

4 No action taken by the United States, an Indian tribe,
5 or tribal organization to enforce the right of recovery pro-
6 vided under this section shall operate to deny to the in-
7 jured person the recovery for that portion of the person’s
8 damage not covered hereunder.

9 “(e) ENFORCEMENT.—

10 “(1) IN GENERAL.—The United States, an In-
11 dian tribe, or tribal organization may enforce the
12 right of recovery provided under subsection (a) by—

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

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

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

20 “(B) instituting a separate civil action, in-
21 cluding a civil action for injunctive relief and
22 other relief and including, with respect to a po-
23 litical subdivision or local governmental entity
24 of a State, such an action against an official
25 thereof.

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

6 “(3) RECOVERY FROM TORTFEASORS.—

7 “(A) IN GENERAL.—In any case in which
8 an Indian tribe or tribal organization that is
9 authorized or required under a compact or con-
10 tract issued pursuant to the Indian Self-Deter-
11 mination and Education Assistance Act (25
12 U.S.C. 450 et seq.) to furnish or pay for health
13 services to a person who is injured or suffers a
14 disease on or after the date of enactment of the
15 Indian Health Care Improvement Reauthoriza-
16 tion and Extension Act of 2009 under cir-
17 cumstances that establish grounds for a claim
18 of liability against the tortfeasor with respect to
19 the injury or disease, the Indian tribe or tribal
20 organization shall have a right to recover from
21 the tortfeasor (or an insurer of the tortfeasor)
22 the reasonable value of the health services so
23 furnished, paid for, or to be paid for, in accord-
24 ance with the Federal Medical Care Recovery
25 Act (42 U.S.C. 2651 et seq.), to the same ex-

1 tent and under the same circumstances as the
2 United States may recover under that Act.

3 “(B) TREATMENT.—The right of an In-
4 dian tribe or tribal organization to recover
5 under subparagraph (A) shall be independent of
6 the rights of the injured or diseased person
7 served by the Indian tribe or tribal organiza-
8 tion.

9 “(f) LIMITATION.—Absent specific written authoriza-
10 tion by the governing body of an Indian tribe for the pe-
11 riod of such authorization (which may not be for a period
12 of more than 1 year and which may be revoked at any
13 time upon written notice by the governing body to the
14 Service), the United States shall not have a right of recov-
15 ery under this section if the injury, illness, or disability
16 for which health services were provided is covered under
17 a self-insurance plan funded by an Indian tribe, tribal or-
18 ganization, or urban Indian organization. Where such au-
19 thorization is provided, the Service may receive and ex-
20 pend such amounts for the provision of additional health
21 services consistent with such authorization.

22 “(g) COSTS AND ATTORNEY’S FEES.—In any action
23 brought to enforce the provisions of this section, a pre-
24 vailing plaintiff shall be awarded its reasonable attorney’s
25 fees and costs of litigation.

1 “(h) NONAPPLICABILITY OF CLAIMS FILING RE-
2 QUIREMENTS.—An insurance company, health mainte-
3 nance organization, self-insurance plan, managed care
4 plan, or other health care plan or program (under the So-
5 cial Security Act or otherwise) may not deny a claim for
6 benefits submitted by the Service or by an Indian tribe
7 or tribal organization based on the format in which the
8 claim is submitted if such format complies with the format
9 required for submission of claims under title XVIII of the
10 Social Security Act or recognized under section 1175 of
11 such Act.

12 “(i) APPLICATION TO URBAN INDIAN ORGANIZA-
13 TIONS.—The previous provisions of this section shall apply
14 to urban Indian organizations with respect to populations
15 served by such Organizations in the same manner they
16 apply to Indian tribes and tribal organizations with re-
17 spect to populations served by such Indian tribes and trib-
18 al organizations.

19 “(j) STATUTE OF LIMITATIONS.—The provisions of
20 section 2415 of title 28, United States Code, shall apply
21 to all actions commenced under this section, and the ref-
22 erences therein to the United States are deemed to include
23 Indian tribes, tribal organizations, and urban Indian orga-
24 nizations.

1 “(k) SAVINGS.—Nothing in this section shall be con-
2 strued to limit any right of recovery available to the
3 United States, an Indian tribe, or tribal organization
4 under the provisions of any applicable, Federal, State, or
5 tribal law, including medical lien laws.”.

6 **SEC. 126. CREDITING OF REIMBURSEMENTS.**

7 Section 207 of the Indian Health Care Improvement
8 Act (25 U.S.C. 1621f) is amended to read as follows:

9 **“SEC. 207. CREDITING OF REIMBURSEMENTS.**

10 “(a) USE OF AMOUNTS.—

11 “(1) RETENTION BY PROGRAM.—Except as pro-
12 vided in sections 202(a)(2) and 813, all reimburse-
13 ments received or recovered under any of the pro-
14 grams described in paragraph (2), including under
15 section 813, by reason of the provision of health
16 services by the Service, by an Indian tribe or tribal
17 organization, or by an urban Indian organization,
18 shall be credited to the Service, such Indian tribe or
19 tribal organization, or such urban Indian organiza-
20 tion, respectively, and may be used as provided in
21 section 401. In the case of such a service provided
22 by or through a Service Unit, such amounts shall be
23 credited to such unit and used for such purposes.

24 “(2) PROGRAMS COVERED.—The programs re-
25 ferred to in paragraph (1) are the following:

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

3 “(B) This Act, including section 813.

4 “(C) Public Law 87–693.

5 “(D) Any other provision of law.

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

10 **SEC. 127. BEHAVIORAL HEALTH TRAINING AND COMMU-**
11 **NITY EDUCATION PROGRAMS.**

12 Section 209 of the Indian Health Care Improvement
13 Act (25 U.S.C. 1621h) is amended by striking subsection
14 (d) and inserting the following:

15 “(d) BEHAVIORAL HEALTH TRAINING AND COMMU-
16 NITY EDUCATION PROGRAMS.—

17 “(1) STUDY; LIST.—The Secretary, acting
18 through the Service, and the Secretary of the Inte-
19 rior, in consultation with Indian tribes and tribal or-
20 ganizations, shall conduct a study and compile a list
21 of the types of staff positions specified in paragraph
22 (2) whose qualifications include, or should include,
23 training in the identification, prevention, education,
24 referral, or treatment of mental illness, or dysfunc-
25 tional and self destructive behavior.

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

3 “(A) staff positions within the Bureau of
4 Indian Affairs, including existing positions, in
5 the fields of—

6 “(i) elementary and secondary edu-
7 cation;

8 “(ii) social services and family and
9 child welfare;

10 “(iii) law enforcement and judicial
11 services; and

12 “(iv) alcohol and substance abuse;

13 “(B) staff positions within the Service; and

14 “(C) staff positions similar to those identi-
15 fied in subparagraphs (A) and (B) established
16 and maintained by Indian tribes and tribal or-
17 ganizations (without regard to the funding
18 source).

19 “(3) TRAINING CRITERIA.—

20 “(A) IN GENERAL.—The appropriate Sec-
21 retary shall provide training criteria appropriate
22 to each type of position identified in paragraphs
23 (2)(A) and (2)(B) and ensure that appropriate
24 training has been, or shall be provided to any
25 individual in any such position. With respect to

1 any such individual in a position identified pur-
2 suant to paragraph (2)(C), the respective Secre-
3 taries shall provide appropriate training to, or
4 provide funds to, an Indian tribe or tribal orga-
5 nization for training of appropriate individuals.
6 In the case of positions funded under a contract
7 or compact under the Indian Self-Determina-
8 tion and Education Assistance Act (25 U.S.C.
9 450 et seq.), the appropriate Secretary shall en-
10 sure that such training costs are included in the
11 contract or compact, as the Secretary deter-
12 mines necessary.

13 “(B) POSITION SPECIFIC TRAINING CRI-
14 TERIA.—Position specific training criteria shall
15 be culturally relevant to Indians and Indian
16 tribes and shall ensure that appropriate infor-
17 mation regarding traditional health care prac-
18 tices is provided.

19 “(4) COMMUNITY EDUCATION ON MENTAL ILL-
20 NESS.—The Service shall develop and implement, on
21 request of an Indian tribe, tribal organization, or
22 urban Indian organization, or assist the Indian tribe,
23 tribal organization, or urban Indian organization to
24 develop and implement, a program of community
25 education on mental illness. In carrying out this

1 paragraph, the Service shall, upon request of an In-
2 dian tribe, tribal organization, or urban Indian orga-
3 nization, provide technical assistance to the Indian
4 tribe, tribal organization, or urban Indian organiza-
5 tion to obtain and develop community educational
6 materials on the identification, prevention, referral,
7 and treatment of mental illness and dysfunctional
8 and self-destructive behavior.

9 “(5) PLAN.—Not later than 90 days after the
10 date of enactment of the Indian Health Care Im-
11 provement Reauthorization and Extension Act of
12 2009, the Secretary shall develop a plan under which
13 the Service will increase the health care staff pro-
14 viding behavioral health services by at least 500 po-
15 sitions within 5 years after the date of enactment of
16 that Act, with at least 200 of such positions devoted
17 to child, adolescent, and family services. The plan
18 developed under this paragraph shall be imple-
19 mented under the Act of November 2, 1921 (25
20 U.S.C. 13) (commonly known as the ‘Snyder Act’).”.

21 **SEC. 128. CANCER SCREENINGS.**

22 Section 212 of the Indian Health Care Improvement
23 Act (25 U.S.C. 1621k) is amended by inserting “and other
24 cancer screenings” before the period at the end.

1 **SEC. 129. PATIENT TRAVEL COSTS.**

2 Section 213 of the Indian Health Care Improvement
3 Act (25 U.S.C. 16211) is amended to read as follows:

4 **“SEC. 213. PATIENT TRAVEL COSTS.**

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

7 “(1) an adult escort (including a parent, guard-
8 ian, or other family member) who is required be-
9 cause of the physical or mental condition, or age, of
10 the applicable patient;

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

14 “(3) other escorts, as the Secretary or applica-
15 ble Indian Health Program determines to be appro-
16 priate.

17 “(b) **PROVISION OF FUNDS.**—The Secretary, acting
18 through the Service and Tribal Health Programs, is au-
19 thorized to provide funds for the following patient travel
20 costs, including qualified escorts, associated with receiving
21 health care services provided (either through direct or con-
22 tract care or through a contract or compact under the In-
23 dian Self-Determination and Education Assistance Act
24 (25 U.S.C. 450 et seq.)) under this Act—

1 “(1) emergency air transportation and non-
2 emergency air transportation where ground trans-
3 portation is infeasible;

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

7 “(3) transportation by such other means as
8 may be available and required when air or motor ve-
9 hicle transportation is not available.”.

10 **SEC. 130. EPIDEMIOLOGY CENTERS.**

11 Section 214 of the Indian Health Care Improvement
12 Act (25 U.S.C. 1621m) is amended to read as follows:

13 **“SEC. 214. EPIDEMIOLOGY CENTERS.**

14 “(a) ESTABLISHMENT OF CENTERS.—

15 “(1) IN GENERAL.—The Secretary shall estab-
16 lish an epidemiology center in each Service area to
17 carry out the functions described in subsection (b).

18 “(2) NEW CENTERS.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (B), any new center established after the
21 date of enactment of the Indian Health Care
22 Improvement Reauthorization and Extension
23 Act of 2009 may be operated under a grant au-
24 thorized by subsection (d).

1 “(B) REQUIREMENT.—Funding provided
2 in a grant described in subparagraph (A) shall
3 not be divisible.

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

9 “(b) FUNCTIONS OF CENTERS.—In consultation with
10 and on the request of Indian tribes, tribal organizations,
11 and urban Indian organizations, each Service area epide-
12 miology center established under this section shall, with
13 respect to the applicable Service area—

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

19 “(2) evaluate existing delivery systems, data
20 systems, and other systems that impact the improve-
21 ment of Indian health;

22 “(3) assist Indian tribes, tribal organizations,
23 and urban Indian organizations in identifying high-
24 est-priority health status objectives and the services

1 needed to achieve those objectives, based on epide-
2 miological data;

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

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

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

12 “(7) provide disease surveillance and assist In-
13 dian tribes, tribal organizations, and urban Indian
14 communities to promote public health.

15 “(c) TECHNICAL ASSISTANCE.—The Director of the
16 Centers for Disease Control and Prevention shall provide
17 technical assistance to the centers in carrying out this sec-
18 tion.

19 “(d) GRANTS FOR STUDIES.—

20 “(1) IN GENERAL.—The Secretary may make
21 grants to Indian tribes, tribal organizations, Indian
22 organizations, and eligible intertribal consortia to
23 conduct epidemiological studies of Indian commu-
24 nities.

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

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

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

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

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

16 “(A) demonstrate the technical, adminis-
17 trative, and financial expertise necessary to
18 carry out the functions described in paragraph
19 (5);

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

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

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

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

5 “(B) to provide information to, and consult
6 with, tribal leaders, urban Indian community
7 leaders, and related health staff regarding
8 health care and health service management
9 issues; and

10 “(C) in collaboration with Indian tribes,
11 tribal organizations, and urban Indian organi-
12 zations, to provide to the Service information
13 regarding ways to improve the health status of
14 Indians.

15 “(e) ACCESS TO INFORMATION.—

16 “(1) IN GENERAL.—An epidemiology center op-
17 erated by a grantee pursuant to a grant awarded
18 under subsection (d) shall be treated as a public
19 health authority (as defined in section 164.501 of
20 title 45, Code of Federal Regulations (or a successor
21 regulation)) for purposes of the Health Insurance
22 Portability and Accountability Act of 1996 (Public
23 Law 104–191; 110 Stat. 1936).

24 “(2) ACCESS TO INFORMATION.—The Secretary
25 shall grant to each epidemiology center described in

1 paragraph (1) access to use of the data, data sets,
2 monitoring systems, delivery systems, and other pro-
3 tected health information in the possession of the
4 Secretary.

5 “(3) REQUIREMENT.—The activities of an epi-
6 demiology center described in paragraph (1) shall be
7 for the purposes of research and for preventing and
8 controlling disease, injury, or disability (as those ac-
9 tivities are described in section 164.512 of title 45,
10 Code of Federal Regulations (or a successor regula-
11 tion)), for purposes of the Health Insurance Port-
12 ability and Accountability Act of 1996 (Public
13 Law 104–191; 110 Stat. 1936).”.

14 **SEC. 131. INDIAN YOUTH GRANT PROGRAM.**

15 Section 216(b)(2) of the Indian Health Care Im-
16 provement Act (25 U.S.C. 1621o(b)(2)) is amended by
17 striking “section 209(m)” and inserting “section 708(e)”.

18 **SEC. 132. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
19 **GRAM.**

20 Section 217 of the Indian Health Care Improvement
21 Act (25 U.S.C. 1621p) is amended to read as follows:

22 **“SEC. 217. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
23 **GRAM.**

24 “(a) GRANTS AUTHORIZED.—The Secretary, acting
25 through the Service, shall make grants of not more than

1 \$300,000 to each of 9 colleges and universities for the pur-
2 pose of developing and maintaining Indian psychology ca-
3 reer recruitment programs as a means of encouraging In-
4 dians to enter the behavioral health field. These programs
5 shall be located at various locations throughout the coun-
6 try to maximize their availability to Indian students and
7 new programs shall be established in different locations
8 from time to time.

9 “(b) QUENTIN N. BURDICK PROGRAM GRANT.—The
10 Secretary shall provide a grant authorized under sub-
11 section (a) to develop and maintain a program at the Uni-
12 versity of North Dakota to be known as the ‘Quentin N.
13 Burdick American Indians Into Psychology Program’.
14 Such program shall, to the maximum extent feasible, co-
15 ordinate with the Quentin N. Burdick Indian health pro-
16 grams authorized under section 117(b), the Quentin N.
17 Burdick American Indians Into Nursing Program author-
18 ized under section 115(e), and existing university research
19 and communications networks.

20 “(c) REGULATIONS.—The Secretary shall issue regu-
21 lations pursuant to this Act for the competitive awarding
22 of grants provided under this section.

23 “(d) CONDITIONS OF GRANT.—Applicants under this
24 section shall agree to provide a program which, at a min-
25 imum—

1 “(1) provides outreach and recruitment for
2 health professions to Indian communities including
3 elementary, secondary, and accredited and accessible
4 community colleges that will be served by the pro-
5 gram;

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

9 “(3) provides summer enrichment programs to
10 expose Indian students to the various fields of psy-
11 chology through research, clinical, and experimental
12 activities;

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

15 “(5) develops affiliation agreements with tribal
16 colleges and universities, the Service, university af-
17 filiated programs, and other appropriate accredited
18 and accessible entities to enhance the education of
19 Indian students;

20 “(6) to the maximum extent feasible, uses exist-
21 ing university tutoring, counseling, and student sup-
22 port services; and

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

1 “(e) ACTIVE DUTY SERVICE REQUIREMENT.—The
2 active duty service obligation prescribed under section
3 338C of the Public Health Service Act (42 U.S.C. 254m)
4 shall be met by each graduate who receives a stipend de-
5 scribed in subsection (d)(4) that is funded under this sec-
6 tion. Such obligation shall be met by service—

7 “(1) in an Indian health program;

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

9 “(3) in the private practice of psychology if, as
10 determined by the Secretary, in accordance with
11 guidelines promulgated by the Secretary, such prac-
12 tice is situated in a physician or other health profes-
13 sional shortage area and addresses the health care
14 needs of a substantial number of Indians.

15 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
16 is authorized to be appropriated to carry out this section
17 \$2,700,000 for fiscal year 2010 and each fiscal year there-
18 after.”.

19 **SEC. 133. PREVENTION, CONTROL, AND ELIMINATION OF**
20 **COMMUNICABLE AND INFECTIOUS DISEASES.**

21 Section 218 of the Indian Health Care Improvement
22 Act (25 U.S.C. 1621q) is amended to read as follows:

1 **“SEC. 218. PREVENTION, CONTROL, AND ELIMINATION OF**
2 **COMMUNICABLE AND INFECTIOUS DISEASES.**

3 “(a) GRANTS AUTHORIZED.—The Secretary, acting
4 through the Service, and after consultation with the Cen-
5 ters for Disease Control and Prevention, may make grants
6 available to Indian tribes and tribal organizations for the
7 following:

8 “(1) Projects for the prevention, control, and
9 elimination of communicable and infectious diseases,
10 including tuberculosis, hepatitis, HIV, respiratory
11 syncytial virus, hanta virus, sexually transmitted dis-
12 eases, and H. pylori.

13 “(2) Public information and education pro-
14 grams for the prevention, control, and elimination of
15 communicable and infectious diseases.

16 “(3) Education, training, and clinical skills im-
17 provement activities in the prevention, control, and
18 elimination of communicable and infectious diseases
19 for health professionals, including allied health pro-
20 fessionals.

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

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

1 “(c) COORDINATION WITH HEALTH AGENCIES.—In-
2 dian tribes and tribal organizations receiving funding
3 under this section are encouraged to coordinate their ac-
4 tivities with the Centers for Disease Control and Preven-
5 tion and State and local health agencies.

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

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

10 “(2) shall prepare and submit a report to Con-
11 gress biennially on the use of funds under this sec-
12 tion and on the progress made toward the preven-
13 tion, control, and elimination of communicable and
14 infectious diseases among Indians and urban Indi-
15 ans.”.

16 **SEC. 134. METHODS TO INCREASE CLINICIAN RECRUIT-**
17 **MENT AND RETENTION ISSUES.**

18 (a) LICENSING.—Section 221 of the Indian Health
19 Care Improvement Act (25 U.S.C. 1621t) is amended to
20 read as follows:

21 **“SEC. 221. LICENSING.**

22 “Licensed health professionals employed by a tribal
23 health program shall be exempt, if licensed in any State,
24 from the licensing requirements of the State in which the
25 tribal health program performs the services described in

1 the contract or compact of the tribal health program under
2 the Indian Self-Determination and Education Assistance
3 Act (25 U.S.C. 450 et seq.).”.

4 (b) TREATMENT OF SCHOLARSHIPS FOR CERTAIN
5 PURPOSES.—Title I of the Indian Health Care Improve-
6 ment Act (25 U.S.C. 1611 et seq.) (as amended by section
7 113) is amended by adding at the end the following:

8 **“SEC. 125. TREATMENT OF SCHOLARSHIPS FOR CERTAIN**
9 **PURPOSES.**

10 “A scholarship provided to an individual pursuant to
11 this title shall be considered to be a qualified scholarship
12 for purposes of section 117 of the Internal Revenue Code
13 of 1986.”.

14 (c) CONTINUING EDUCATION ALLOWANCES.—Sec-
15 tion 106 of the Indian Health Care Improvement Act (25
16 U.S.C. 1615) is amended to read as follows:

17 **“SEC. 106. CONTINUING EDUCATION ALLOWANCES.**

18 “In order to encourage scholarship and stipend re-
19 cipients under sections 104, 105, and 115 and health pro-
20 fessionals, including community health representatives
21 and emergency medical technicians, to join or continue in
22 an Indian health program and to provide services in the
23 rural and remote areas in which a significant portion of
24 Indians reside, the Secretary, acting through the Service,
25 may—

1 “(1) provide programs or allowances to transi-
2 tion into an Indian health program, including licens-
3 ing, board or certification examination assistance,
4 and technical assistance in fulfilling service obliga-
5 tions under sections 104, 105, and 115; and

6 “(2) provide programs or allowances to health
7 professionals employed in an Indian health program
8 to enable those professionals, for a period of time
9 each year prescribed by regulation of the Secretary,
10 to take leave of the duty stations of the professionals
11 for professional consultation, management, leader-
12 ship, and refresher training courses.”.

13 **SEC. 135. LIABILITY FOR PAYMENT.**

14 Section 222 of the Indian Health Care Improvement
15 Act (25 U.S.C. 1621u) is amended to read as follows:

16 **“SEC. 222. LIABILITY FOR PAYMENT.**

17 “(a) NO PATIENT LIABILITY.—A patient who re-
18 ceives contract health care services that are authorized by
19 the Service shall not be liable for the payment of any
20 charges or costs associated with the provision of such serv-
21 ices.

22 “(b) NOTIFICATION.—The Secretary shall notify a
23 contract care provider and any patient who receives con-
24 tract health care services authorized by the Service that
25 such patient is not liable for the payment of any charges

1 or costs associated with the provision of such services not
2 later than 5 business days after receipt of a notification
3 of a claim by a provider of contract care services.

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

9 **SEC. 136. OFFICES OF INDIAN MEN’S HEALTH AND INDIAN**
10 **WOMEN’S HEALTH.**

11 Section 223 of the Indian Health Care Improvement
12 Act (25 U.S.C. 1621v) is amended—

13 (1) by striking the section designation and
14 heading and all that follows through “oversee efforts
15 of the Service to” and inserting the following:

16 **“SEC. 223. OFFICES OF INDIAN MEN’S HEALTH AND INDIAN**
17 **WOMEN’S HEALTH.**

18 “(a) OFFICE OF INDIAN MEN’S HEALTH.—

19 “(1) ESTABLISHMENT.—The Secretary may es-
20 tablish within the Service an office, to be known as
21 the ‘Office of Indian Men’s Health’.

22 “(2) DIRECTOR.—

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

1 “(B) DUTIES.—The director shall coordi-
2 nate and promote the health status of Indian
3 men in the United States.

4 “(3) REPORT.—Not later than 2 years after the
5 date of enactment of the Indian Health Care Im-
6 provement Reauthorization and Extension Act of
7 2009, the Secretary, acting through the Service,
8 shall submit to Congress a report describing—

9 “(A) any activity carried out by the direc-
10 tor as of the date on which the report is pre-
11 pared; and

12 “(B) any finding of the director with re-
13 spect to the health of Indian men.

14 “(b) OFFICE OF INDIAN WOMEN’S HEALTH.—The
15 Secretary, acting through the Service, shall establish an
16 office, to be known as the ‘Office of Indian Women’s
17 Health’, to”;

18 (2) in subsection (b) (as so redesignated) by in-
19 serting “(including urban Indian women)” before
20 “of all ages”.

21 **SEC. 137. CONTRACT HEALTH SERVICE ADMINISTRATION**
22 **AND DISBURSEMENT FORMULA.**

23 Title II of the Indian Health Care Improvement Act
24 (25 U.S.C. 1621 et seq.) is amended by adding at the end
25 the following:

1 **“SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION**
2 **AND DISBURSEMENT FORMULA.**

3 “(a) SUBMISSION OF REPORT.—As soon as prac-
4 ticable after the date of enactment of the Indian Health
5 Care Improvement Reauthorization and Extension Act of
6 2009, the Comptroller General of the United States shall
7 submit to the Secretary, the Committee on Indian Affairs
8 of the Senate, and the Committee on Natural Resources
9 of the House of Representatives, and make available to
10 each Indian tribe, a report describing the results of the
11 study of the Comptroller General regarding the funding
12 of the contract health service program (including historic
13 funding levels and a recommendation of the funding level
14 needed for the program) and the administration of the
15 contract health service program (including the distribution
16 of funds pursuant to the program), as requested by Con-
17 gress in March 2009, or pursuant to section 830.

18 “(b) CONSULTATION WITH TRIBES.—On receipt of
19 the report under subsection (a), the Secretary shall con-
20 sult with Indian tribes regarding the contract health serv-
21 ice program, including the distribution of funds pursuant
22 to the program—

23 “(1) to determine whether the current distribu-
24 tion formula would require modification if the con-
25 tract health service program were funded at the level
26 recommended by the Comptroller General;

1 “(2) to identify any inequities in the current
2 distribution formula under the current funding level
3 or inequitable results for any Indian tribe under the
4 funding level recommended by the Comptroller Gen-
5 eral;

6 “(3) to identify any areas of program adminis-
7 tration that may result in the inefficient or ineffec-
8 tive management of the program; and

9 “(4) to identify any other issues and rec-
10 ommendations to improve the administration of the
11 contract health services program and correct any un-
12 fair results or funding disparities identified under
13 paragraph (2).

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

22 **Subtitle C—Health Facilities**

23 **SEC. 141. HEALTH CARE FACILITY PRIORITY SYSTEM.**

24 Section 301 of the Indian Health Care Improvement
25 Act (25 U.S.C. 1631) is amended—

1 (1) by redesignating subsection (d) as sub-
2 section (h); and

3 (2) by striking subsection (c) and inserting the
4 following:

5 “(c) HEALTH CARE FACILITY PRIORITY SYSTEM.—

6 “(1) IN GENERAL.—

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

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

12 “(ii) shall give Indian tribes’ needs
13 the highest priority;

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

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

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

22 “(iv) shall provide an opportunity for
23 the nomination of planning, design, and
24 construction projects by the Service, In-
25 dian tribes, and tribal organizations for

1 consideration under the priority system at
2 least once every 3 years, or more fre-
3 quently as the Secretary determines to be
4 appropriate.

5 “(B) NEEDS OF FACILITIES UNDER
6 ISDEAA AGREEMENTS.—The Secretary shall en-
7 sure that the planning, design, construction,
8 renovation, and expansion needs of Service and
9 non-Service facilities operated under contracts
10 or compacts in accordance with the Indian Self-
11 Determination and Education Assistance Act
12 (25 U.S.C. 450 et seq.) are fully and equitably
13 integrated into the health care facility priority
14 system.

15 “(C) CRITERIA FOR EVALUATING
16 NEEDS.—For purposes of this subsection, the
17 Secretary, in evaluating the needs of facilities
18 operated under a contract or compact under the
19 Indian Self-Determination and Education As-
20 sistance Act (25 U.S.C. 450 et seq.), shall use
21 the criteria used by the Secretary in evaluating
22 the needs of facilities operated directly by the
23 Service.

24 “(D) PRIORITY OF CERTAIN PROJECTS
25 PROTECTED.—The priority of any project estab-

1 lished under the construction priority system in
2 effect on the date of enactment of the Indian
3 Health Care Improvement Reauthorization and
4 Extension Act of 2009 shall not be affected by
5 any change in the construction priority system
6 taking place after that date if the project—

7 “(i) was identified in the fiscal year
8 2008 Service budget justification as—

9 “(I) 1 of the 10 top-priority inpa-
10 tient projects;

11 “(II) 1 of the 10 top-priority out-
12 patient projects;

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

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

17 “(ii) had completed both Phase I and
18 Phase II of the construction priority sys-
19 tem in effect on the date of enactment of
20 such Act; or

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

24 “(I) on the initiative of the Sec-
25 retary; or

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

3 “(2) REPORT; CONTENTS.—

4 “(A) INITIAL COMPREHENSIVE REPORT.—

5 “(i) DEFINITIONS.—In this subpara-
6 graph:

7 “(I) FACILITIES APPROPRIATION
8 ADVISORY BOARD.—The term ‘Facili-
9 ties Appropriation Advisory Board’
10 means the advisory board, comprised
11 of 12 members representing Indian
12 tribes and 2 members representing
13 the Service, established at the discre-
14 tion of the Director—

15 “(aa) to provide advice and
16 recommendations for policies and
17 procedures of the programs fund-
18 ed pursuant to facilities appro-
19 priations; and

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

22 “(II) FACILITIES NEEDS ASSESS-
23 MENT WORKGROUP.—The term ‘Fa-
24 cilities Needs Assessment Workgroup’

1 means the workgroup established at
2 the discretion of the Director—

3 “(aa) to review the health
4 care facilities construction pri-
5 ority system; and

6 “(bb) to make recommenda-
7 tions to the Facilities Appropria-
8 tion Advisory Board for revising
9 the priority system.

10 “(ii) INITIAL REPORT.—

11 “(I) IN GENERAL.—Not later
12 than 1 year after the date of enact-
13 ment of the Indian Health Care Im-
14 provement Reauthorization and Ex-
15 tension Act of 2009, the Secretary
16 shall submit to the Committee on In-
17 dian Affairs of the Senate and the
18 Committee on Natural Resources of
19 the House of Representatives a report
20 that describes the comprehensive, na-
21 tional, ranked list of all health care
22 facilities needs for the Service, Indian
23 tribes, and tribal organizations (in-
24 cluding inpatient health care facilities,
25 outpatient health care facilities, spe-

1 cialized health care facilities (such as
2 for long-term care and alcohol and
3 drug abuse treatment), wellness cen-
4 ters, and staff quarters, and the ren-
5 ovation and expansion needs, if any,
6 of such facilities) developed by the
7 Service, Indian tribes, and tribal orga-
8 nizations for the Facilities Needs As-
9 sessment Workgroup and the Facili-
10 ties Appropriation Advisory Board.

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

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

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

21 “(iii) UPDATES OF REPORT.—Begin-
22 ning in calendar year 2011, the Secretary
23 shall—

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

4 “(II) include the updated report
5 in the appropriate annual report
6 under subparagraph (B) for submis-
7 sion to Congress under section 801.

8 “(B) ANNUAL REPORTS.—The Secretary
9 shall submit to the President, for inclusion in
10 the report required to be transmitted to Con-
11 gress under section 801, a report which sets
12 forth the following:

13 “(i) A description of the health care
14 facility priority system of the Service es-
15 tablished under paragraph (1).

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

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

20 “(II) the 10 top-priority out-
21 patient health care facilities;

22 “(III) the 10 top-priority special-
23 ized health care facilities (such as
24 long-term care and alcohol and drug
25 abuse treatment); and

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

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

6 “(iv) The projected cost of such
7 projects.

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

11 “(3) REQUIREMENTS FOR PREPARATION OF RE-
12 PORTS.—In preparing the report required under
13 paragraph (2), the Secretary shall—

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

17 “(B) review the total unmet needs of all
18 Indian tribes and tribal organizations for health
19 care facilities (including staff quarters), includ-
20 ing needs for renovation and expansion of exist-
21 ing facilities.

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

24 “(1) IN GENERAL.—Not later than 1 year after
25 the establishment of the priority system under sub-

1 section (c)(1)(A), the Comptroller General of the
2 United States shall prepare and finalize a report re-
3 viewing the methodologies applied, and the processes
4 followed, by the Service in making each assessment
5 of needs for the list under subsection (c)(2)(A)(ii)
6 and developing the priority system under subsection
7 (c)(1), including a review of—

8 “(A) the recommendations of the Facilities
9 Appropriation Advisory Board and the Facili-
10 ties Needs Assessment Workgroup (as those
11 terms are defined in subsection (c)(2)(A)(i));
12 and

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

16 “(2) SUBMISSION TO CONGRESS.—The Comp-
17 troller General of the United States shall submit the
18 report under paragraph (1) to—

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

21 “(B) the Committees on Natural Re-
22 sources and Appropriations of the House of
23 Representatives; and

24 “(C) the Secretary.

1 “(e) FUNDING CONDITION.—All funds appropriated
2 under the Act of November 2, 1921 (25 U.S.C. 13) (com-
3 monly known as the ‘Snyder Act’), for the planning, de-
4 sign, construction, or renovation of health facilities for the
5 benefit of 1 or more Indian Tribes shall be subject to the
6 provisions of section 102 of the Indian Self-Determination
7 and Education Assistance Act (25 U.S.C. 450f) or sec-
8 tions 504 and 505 of that Act (25 U.S.C. 458aaa–3,
9 458aaa–4).

10 “(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—
11 The Secretary shall consult and cooperate with Indian
12 tribes and tribal organizations, and confer with urban In-
13 dian organizations, in developing innovative approaches to
14 address all or part of the total unmet need for construc-
15 tion of health facilities, that may include—

16 “(1) the establishment of an area distribution
17 fund in which a portion of health facility construc-
18 tion funding could be devoted to all Service areas;

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

21 “(3) other approaches, as the Secretary deter-
22 mines to be appropriate.”.

1 **SEC. 142. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.**
2

3 Section 307 of the Indian Health Care Improvement
4 Act (25 U.S.C. 1637) is amended to read as follows:

5 **“SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.**
6

7 “(a) PURPOSE AND GENERAL AUTHORITY.—

8 “(1) PURPOSE.—The purpose of this section is
9 to encourage the establishment of demonstration
10 projects that meet the applicable criteria of this sec-
11 tion to be carried out by the Secretary, acting
12 through the Service, or Indian tribes or tribal orga-
13 nizations acting pursuant to contracts or compacts
14 under the Indian Self Determination and Education
15 Assistance Act (25 U.S.C. 450 et seq.)—

16 “(A) to test alternative means of delivering
17 health care and services to Indians through fa-
18 cilities; or

19 “(B) to use alternative or innovative meth-
20 ods or models of delivering health care services
21 to Indians (including primary care services,
22 contract health services, or any other program
23 or service authorized by this Act) through con-
24 venient care services (as defined in subsection
25 (c)), community health centers, or cooperative
26 agreements or arrangements with other health

1 care providers that share or coordinate the use
2 of facilities, funding, or other resources, or oth-
3 erwise coordinate or improve the coordination of
4 activities of the Service, Indian tribes, or tribal
5 organizations, with those of the other health
6 care providers.

7 “(2) AUTHORITY.—The Secretary, acting
8 through the Service, is authorized to carry out, or to
9 enter into contracts or compacts under the Indian
10 Self-Determination and Education Assistance Act
11 (25 U.S.C. 450 et seq.) with Indian tribes or tribal
12 organizations to carry out, health care delivery dem-
13 onstration projects that—

14 “(A) test alternative means of delivering
15 health care and services to Indians through fa-
16 cilities; or

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

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

21 “(1) may authorize such contracts for the con-
22 struction and renovation of hospitals, health centers,
23 health stations, and other facilities to deliver health
24 care services; and

25 “(2) is authorized—

1 “(A) to waive any leasing prohibition;

2 “(B) to permit use and carryover of funds
3 appropriated for the provision of health care
4 services under this Act (including for the pur-
5 chase of health benefits coverage, as authorized
6 by section 402(a));

7 “(C) to permit the use of other available
8 funds, including other Federal funds, funds
9 from third-party collections in accordance with
10 sections 206, 207, and 401, and non-Federal
11 funds contributed by State or local govern-
12 mental agencies or facilities or private health
13 care providers pursuant to cooperative or other
14 agreements with the Service, 1 or more Indian
15 tribes, or tribal organizations;

16 “(D) to permit the use of funds or prop-
17 erty donated or otherwise provided from any
18 source for project purposes;

19 “(E) to provide for the reversion of do-
20 nated real or personal property to the donor;
21 and

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

24 “(c) HEALTH CARE DEMONSTRATION PROJECTS.—

1 “(1) DEFINITION OF CONVENIENT CARE SERV-
2 ICE.—In this subsection, the term ‘convenient care
3 service’ means any primary health care service, such
4 as urgent care services, nonemergent care services,
5 prevention services and screenings, and any service
6 authorized by section 203 or 205(d), that is of-
7 fered—

8 “(A) at an alternative setting; or

9 “(B) during hours other than regular
10 working hours.

11 “(2) GENERAL PROJECTS.—

12 “(A) CRITERIA.—The Secretary may ap-
13 prove under this section demonstration projects
14 that meet the following criteria:

15 “(i) There is a need for a new facility
16 or program, such as a program for conven-
17 ient care services, or an improvement in,
18 increased efficiency at, or reorientation of
19 an existing facility or program.

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

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

1 “(iv) The project is economically via-
2 ble.

3 “(v) For projects carried out by an
4 Indian tribe or tribal organization, the In-
5 dian tribe or tribal organization has the
6 administrative and financial capability to
7 administer the project.

8 “(vi) The project is integrated with
9 providers of related health or social serv-
10 ices (including State and local health care
11 agencies or other health care providers)
12 and is coordinated with, and avoids dupli-
13 cation of, existing services in order to ex-
14 pand the availability of services.

15 “(B) PRIORITY.—In approving demonstra-
16 tion projects under this paragraph, the Sec-
17 retary shall give priority to demonstration
18 projects, to the extent the projects meet the cri-
19 teria described in subparagraph (A), located in
20 any of the following Service units:

21 “(i) Cass Lake, Minnesota.

22 “(ii) Mescalero, New Mexico.

23 “(iii) Owyhee and Elko, Nevada.

24 “(iv) Schurz, Nevada.

25 “(v) Ft. Yuma, California.

1 “(3) INNOVATIVE HEALTH SERVICES DELIVERY
2 DEMONSTRATION PROJECT.—

3 “(A) APPLICATION OR REQUEST.—On re-
4 ceipt of an application or request from an In-
5 dian tribe, a consortium of Indian tribes, or a
6 tribal organization within a Service area, the
7 Secretary shall take into consideration alter-
8 native or innovated methods to deliver health
9 care services within the Service area (or a por-
10 tion of, or facility within, the Service area) as
11 described in the application or request, includ-
12 ing medical, dental, pharmaceutical, nursing,
13 clinical laboratory, contract health services, con-
14 venient care services, community health centers,
15 or any other health care services delivery mod-
16 els designed to improve access to, or efficiency
17 or quality of, the health care, health promotion,
18 or disease prevention services and programs
19 under this Act.

20 “(B) APPROVAL.—In addition to projects
21 described in paragraph (2), in any fiscal year,
22 the Secretary is authorized under this para-
23 graph to approve not more than 10 applications
24 for health care delivery demonstration projects

1 that meet the criteria described in subpara-
2 graph (C).

3 “(C) CRITERIA.—The Secretary shall ap-
4 prove under subparagraph (B) demonstration
5 projects that meet all of the following criteria:

6 “(i) The criteria set forth in para-
7 graph (2)(A).

8 “(ii) There is a lack of access to
9 health care services at existing health care
10 facilities, which may be due to limited
11 hours of operation at those facilities or
12 other factors.

13 “(iii) The project—

14 “(I) expands the availability of
15 services; or

16 “(II) reduces—

17 “(aa) the burden on Con-
18 tract Health Services; or

19 “(bb) the need for emer-
20 gency room visits.

21 “(d) TECHNICAL ASSISTANCE.—On receipt of an ap-
22 plication or request from an Indian tribe, a consortium
23 of Indian tribes, or a tribal organization, the Secretary
24 shall provide such technical and other assistance as may
25 be necessary to enable applicants to comply with this sec-

1 tion, including information regarding the Service unit
2 budget and available funding for carrying out the pro-
3 posed demonstration project.

4 “(e) SERVICE TO INELIGIBLE PERSONS.—Subject to
5 section 813, the authority to provide services to persons
6 otherwise ineligible for the health care benefits of the
7 Service, and the authority to extend hospital privileges in
8 Service facilities to non-Service health practitioners as
9 provided in section 813, may be included, subject to the
10 terms of that section, in any demonstration project ap-
11 proved pursuant to this section.

12 “(f) EQUITABLE TREATMENT.—For purposes of sub-
13 section (c), the Secretary, in evaluating facilities operated
14 under any contract or compact under the Indian Self-De-
15 termination and Education Assistance Act (25 U.S.C. 450
16 et seq.), shall use the same criteria that the Secretary uses
17 in evaluating facilities operated directly by the Service.

18 “(g) EQUITABLE INTEGRATION OF FACILITIES.—
19 The Secretary shall ensure that the planning, design, con-
20 struction, renovation, and expansion needs of Service and
21 non-Service facilities that are the subject of a contract or
22 compact under the Indian Self-Determination and Edu-
23 cation Assistance Act (25 U.S.C. 450 et seq.) for health
24 services are fully and equitably integrated into the imple-

1 mentation of the health care delivery demonstration
2 projects under this section.”.

3 **SEC. 143. TRIBAL MANAGEMENT OF FEDERALLY OWNED**
4 **QUARTERS.**

5 Title III of the Indian Health Care Improvement Act
6 (as amended by section 101(b)) is amended by inserting
7 after section 308 (25 U.S.C. 1638) the following:

8 **“SEC. 309. TRIBAL MANAGEMENT OF FEDERALLY OWNED**
9 **QUARTERS.**

10 “(a) RENTAL RATES.—

11 “(1) ESTABLISHMENT.—Notwithstanding any
12 other provision of law, a tribal health program that
13 operates a hospital or other health facility and the
14 federally owned quarters associated with such a fa-
15 cility pursuant to a contract or compact under the
16 Indian Self-Determination and Education Assistance
17 Act (25 U.S.C. 450 et seq.) may establish the rental
18 rates charged to the occupants of those quarters, on
19 providing notice to the Secretary.

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

23 “(A) to base the rental rates on the rea-
24 sonable value of the quarters to the occupants
25 of the quarters; and

1 “(B) to generate sufficient funds to pru-
2 dently provide for the operation and mainte-
3 nance of the quarters, and at the discretion of
4 the tribal health program, to supply reserve
5 funds for capital repairs and replacement of the
6 quarters.

7 “(3) EQUITABLE FUNDING.—A federally owned
8 quarters the rental rates for which are established
9 by a tribal health program under this subsection
10 shall remain eligible to receive improvement and re-
11 pair funds to the same extent that all federally
12 owned quarters used to house personnel in programs
13 of the Service are eligible to receive those funds.

14 “(4) NOTICE OF RATE CHANGE.—A tribal
15 health program that establishes a rental rate under
16 this subsection shall provide occupants of the feder-
17 ally owned quarters a notice of any change in the
18 rental rate by not later than the date that is 60 days
19 notice before the effective date of the change.

20 “(5) RATES IN ALASKA.—A rental rate estab-
21 lished by a tribal health program under this section
22 for a federally owned quarters in the State of Alaska
23 may be based on the cost of comparable private
24 rental housing in the nearest established community

1 with a year-round population of 1,500 or more indi-
2 viduals.

3 “(b) DIRECT COLLECTION OF RENT.—

4 “(1) IN GENERAL.—Notwithstanding any other
5 provision of law, and subject to paragraph (2), a
6 tribal health program may collect rent directly from
7 Federal employees who occupy federally owned quar-
8 ters if the tribal health program submits to the Sec-
9 retary and the employees a notice of the election of
10 the tribal health program to collect rents directly
11 from the employees.

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

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

18 “(B) the Secretary shall not have the au-
19 thority to collect rent from the employees
20 through payroll deduction or otherwise.

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

23 “(A) shall be retained by the applicable
24 tribal health program in a separate account,
25 which shall be used by the tribal health pro-

1 gram for the maintenance (including capital re-
2 pairs and replacement) and operation of the
3 quarters, as the tribal health program deter-
4 mines to be appropriate; and

5 “(B) shall not be made payable to, or oth-
6 erwise be deposited with, the United States.

7 “(4) RETROCESSION OF AUTHORITY.—If a trib-
8 al health program that elected to collect rent directly
9 under paragraph (1) requests retrocession of the au-
10 thority of the tribal health program to collect that
11 rent, the retrocession shall take effect on the earlier
12 of—

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

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

19 **SEC. 144. OTHER FUNDING, EQUIPMENT, AND SUPPLIES**
20 **FOR FACILITIES.**

21 Title III of the Indian Health Care Improvement Act
22 (25 U.S.C. 1631 et seq.) is amended by adding at the end
23 the following:

1 **“SEC. 311. OTHER FUNDING, EQUIPMENT, AND SUPPLIES**
2 **FOR FACILITIES.**

3 “(a) AUTHORIZATION.—

4 “(1) AUTHORITY TO TRANSFER FUNDS.—The
5 head of any Federal agency to which funds, equip-
6 ment, or other supplies are made available for the
7 planning, design, construction, or operation of a
8 health care or sanitation facility may transfer the
9 funds, equipment, or supplies to the Secretary for
10 the planning, design, construction, or operation of a
11 health care or sanitation facility to achieve—

12 “(A) the purposes of this Act; and

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

16 “(2) AUTHORITY TO ACCEPT FUNDS.—The Sec-
17 retary may—

18 “(A) accept from any source, including
19 Federal and State agencies, funds, equipment,
20 or supplies that are available for the construc-
21 tion or operation of health care or sanitation fa-
22 cilities; and

23 “(B) use those funds, equipment, and sup-
24 plies to plan, design, construct, and operate
25 health care or sanitation facilities for Indians,
26 including pursuant to a contract or compact

1 under the Indian Self-Determination and Edu-
2 cation Assistance Act (25 U.S.C. 450 et seq.).

3 “(3) EFFECT OF RECEIPT.—Receipt of funds
4 by the Secretary under this subsection shall not af-
5 fect any priority established under section 301.

6 “(b) INTERAGENCY AGREEMENTS.—The Secretary
7 may enter into interagency agreements with Federal or
8 State agencies and other entities, and accept funds, equip-
9 ment, or other supplies from those entities, to provide for
10 the planning, design, construction, and operation of health
11 care or sanitation facilities to be administered by Indian
12 health programs to achieve—

13 “(1) the purposes of this Act; and

14 “(2) the purposes for which the funds were ap-
15 propriated or otherwise provided.

16 “(c) ESTABLISHMENT OF STANDARDS.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Service, shall establish, by regulation,
19 standards for the planning, design, construction, and
20 operation of health care or sanitation facilities serv-
21 ing Indians under this Act.

22 “(2) OTHER REGULATIONS.—Notwithstanding
23 any other provision of law, any other applicable reg-
24 ulations of the Department shall apply in carrying

1 out projects using funds transferred under this sec-
2 tion.

3 “(d) DEFINITION OF SANITATION FACILITY.—In this
4 section, the term ‘sanitation facility’ means a safe and
5 adequate water supply system, sanitary sewage disposal
6 system, or sanitary solid waste system (including all re-
7 lated equipment and support infrastructure).”.

8 **SEC. 145. INDIAN COUNTRY MODULAR COMPONENT FACILI-**
9 **TIES DEMONSTRATION PROGRAM.**

10 Title III of the Indian Health Care Improvement Act
11 (25 U.S.C. 1631 et seq.) (as amended by section 144) is
12 amended by adding at the end the following:

13 **“SEC. 312. INDIAN COUNTRY MODULAR COMPONENT FA-**
14 **CILITIES DEMONSTRATION PROGRAM.**

15 “(a) DEFINITION OF MODULAR COMPONENT
16 HEALTH CARE FACILITY.—In this section, the term ‘mod-
17 ular component health care facility’ means a health care
18 facility that is constructed—

19 “(1) off-site using prefabricated component
20 units for subsequent transport to the destination lo-
21 cation; and

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

1 “(b) ESTABLISHMENT.—The Secretary, acting
2 through the Service, shall establish a demonstration pro-
3 gram under which the Secretary shall award no less than
4 3 grants for purchase, installation and maintenance of
5 modular component health care facilities in Indian com-
6 munities for provision of health care services.

7 “(c) SELECTION OF LOCATIONS.—

8 “(1) PETITIONS.—

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

14 “(B) PETITION.—To be eligible to receive
15 a grant under this section, an Indian tribe or
16 tribal organization must submit to the Sec-
17 retary a petition to construct a modular compo-
18 nent health care facility in the Indian commu-
19 nity of the Indian tribe, at such time, in such
20 manner, and containing such information as the
21 Secretary may require.

22 “(2) SELECTION.—In selecting the location of
23 each modular component health care facility to be
24 provided under the demonstration program, the Sec-
25 retary shall give priority to projects already on the

1 Indian Health Service facilities construction priority
2 list and petitions which demonstrate that erection of
3 a modular component health facility—

4 “(A) is more economical than construction
5 of a traditionally constructed health care facil-
6 ity;

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

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

13 “(3) EFFECT OF SELECTION.—A modular com-
14 ponent health care facility project selected for par-
15 ticipation in the demonstration program shall not be
16 eligible for entry on the facilities construction prior-
17 ities list entitled ‘IHS Health Care Facilities FY
18 2011 Planned Construction Budget’ and dated May
19 7, 2009 (or any successor list).

20 “(d) ELIGIBILITY.—

21 “(1) IN GENERAL.—An Indian tribe may sub-
22 mit a petition under subsection (c)(1)(B) regardless
23 of whether the Indian tribe is a party to any con-
24 tract or compact under the Indian Self-Determina-

1 tion and Education Assistance Act (25 U.S.C. 450
2 et seq.).

3 “(2) ADMINISTRATION.—At the election of an
4 Indian tribe or tribal organization selected for par-
5 ticipation in the demonstration program, the funds
6 provided for the project shall be subject to the provi-
7 sions of the Indian Self-Determination and Edu-
8 cation Assistance Act.

9 “(e) REPORTS.—Not later than 1 year after the date
10 on which funds are made available for the demonstration
11 program and annually thereafter, the Secretary shall sub-
12 mit to Congress a report describing—

13 “(1) each activity carried out under the dem-
14 onstration program, including an evaluation of the
15 success of the activity; and

16 “(2) the potential benefits of increased use of
17 modular component health care facilities in other In-
18 dian communities.

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

1 **SEC. 146. MOBILE HEALTH STATIONS DEMONSTRATION**
2 **PROGRAM.**

3 Title III of the Indian Health Care Improvement Act
4 (25 U.S.C. 1631 et seq.) (as amended by section 145) is
5 amended by adding at the end the following:

6 **“SEC. 313. MOBILE HEALTH STATIONS DEMONSTRATION**
7 **PROGRAM.**

8 “(a) DEFINITIONS.—In this section:

9 “(1) ELIGIBLE TRIBAL CONSORTIUM.—The
10 term ‘eligible tribal consortium’ means a consortium
11 composed of 2 or more Service units between which
12 a mobile health station can be transported by road
13 in up to 8 hours. A Service unit operated by the
14 Service or by an Indian tribe or tribal organization
15 shall be equally eligible for participation in such con-
16 sortium.

17 “(2) MOBILE HEALTH STATION.—The term
18 ‘mobile health station’ means a health care unit
19 that—

20 “(A) is constructed, maintained, and capa-
21 ble of being transported within a semi-trailer
22 truck or similar vehicle;

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

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

1 “(3) SPECIALTY HEALTH CARE SERVICE.—

2 “(A) IN GENERAL.—The term ‘specialty
3 health care service’ means a health care service
4 which requires the services of a health care pro-
5 fessional with specialized knowledge or experi-
6 ence.

7 “(B) INCLUSIONS.—The term ‘specialty
8 health care service’ includes any service relating
9 to—

10 “(i) dialysis;

11 “(ii) surgery;

12 “(iii) mammography;

13 “(iv) dentistry; or

14 “(v) any other specialty health care
15 service.

16 “(b) ESTABLISHMENT.—The Secretary, acting
17 through the Service, shall establish a demonstration pro-
18 gram under which the Secretary shall provide at least 3
19 mobile health station projects.

20 “(c) PETITION.—To be eligible to receive a mobile
21 health station under the demonstration program, an eligi-
22 ble tribal consortium shall submit to the Secretary, a peti-
23 tion at such time, in such manner, and containing—

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

1 “(2) a description of the specialty service or
2 services for which the mobile health station is re-
3 quired and the extent to which such service or serv-
4 ices are currently available to the Indian population
5 to be served; and

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

8 “(d) USE OF FUNDS.—The Secretary shall use
9 amounts made available to carry out the demonstration
10 program under this section—

11 “(1)(A) to establish, purchase, lease, or main-
12 tain mobile health stations for the eligible tribal con-
13 sortia selected for projects; and

14 “(B) to provide, through the mobile health sta-
15 tion, such specialty health care services as the af-
16 fected eligible tribal consortium determines to be
17 necessary for the Indian population served;

18 “(2) to employ an existing mobile health station
19 (regardless of whether the mobile health station is
20 owned or rented and operated by the Service) to pro-
21 vide specialty health care services to an eligible trib-
22 al consortium; and

23 “(3) to establish, purchase, or maintain docking
24 equipment for a mobile health station, including the
25 establishment or maintenance of such equipment at

1 a modular component health care facility (as defined
2 in section 312(a)), if applicable.

3 “(e) REPORTS.—Not later than 1 year after the date
4 on which the demonstration program is established under
5 subsection (b) and annually thereafter, the Secretary, act-
6 ing through the Service, shall submit to Congress a report
7 describing—

8 “(1) each activity carried out under the dem-
9 onstration program including an evaluation of the
10 success of the activity; and

11 “(2) the potential benefits of increased use of
12 mobile health stations to provide specialty health
13 care services for Indian communities.

14 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated \$5,000,000 per year to
16 carry out the demonstration program under this section
17 for the first 5 fiscal years, and such sums as may be need-
18 ed to carry out the program in subsequent fiscal years.”.

19 **Subtitle D—Access to Health**
20 **Services**

21 **SEC. 151. TREATMENT OF PAYMENTS UNDER SOCIAL SECU-**
22 **RITY ACT HEALTH BENEFITS PROGRAMS.**

23 Section 401 of the Indian Health Care Improvement
24 Act (25 U.S.C. 1641) is amended to read as follows:

1 **“SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SE-**
2 **CURITY ACT HEALTH BENEFITS PROGRAMS.**

3 “(a) DISREGARD OF MEDICARE, MEDICAID, AND
4 CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—
5 Any payments received by an Indian health program or
6 by an urban Indian organization under title XVIII, XIX,
7 or XXI of the Social Security Act for services provided
8 to Indians eligible for benefits under such respective titles
9 shall not be considered in determining appropriations for
10 the provision of health care and services to Indians.

11 “(b) NONPREFERENTIAL TREATMENT.—Nothing in
12 this Act authorizes the Secretary to provide services to an
13 Indian with coverage under title XVIII, XIX, or XI of the
14 Social Security Act in preference to an Indian without
15 such coverage.

16 “(c) USE OF FUNDS.—

17 “(1) SPECIAL FUND.—

18 “(A) 100 PERCENT PASS-THROUGH OF
19 PAYMENTS DUE TO FACILITIES.—Notwith-
20 standing any other provision of law, but subject
21 to paragraph (2), payments to which a facility
22 of the Service is entitled by reason of a provi-
23 sion of title XVIII or XIX of the Social Secu-
24 rity Act shall be placed in a special fund to be
25 held by the Secretary. In making payments
26 from such fund, the Secretary shall ensure that

1 each Service unit of the Service receives 100
2 percent of the amount to which the facilities of
3 the Service, for which such Service unit makes
4 collections, are entitled by reason of a provision
5 of either such title.

6 “(B) USE OF FUNDS.—Amounts received
7 by a facility of the Service under subparagraph
8 (A) by reason of a provision of title XVIII or
9 XIX of the Social Security Act shall first be
10 used (to such extent or in such amounts as are
11 provided in appropriation Acts) for the purpose
12 of making any improvements in the programs
13 of the Service operated by or through such fa-
14 cility which may be necessary to achieve or
15 maintain compliance with the applicable condi-
16 tions and requirements of such respective title.
17 Any amounts so received that are in excess of
18 the amount necessary to achieve or maintain
19 such conditions and requirements shall, subject
20 to consultation with the Indian tribes being
21 served by the Service unit, be used for reducing
22 the health resource deficiencies (as determined
23 in section 201(c)) of such Indian tribes, includ-
24 ing the provision of services pursuant to section
25 205.

1 “(2) DIRECT PAYMENT OPTION.—Paragraph
2 (1) shall not apply to a tribal health program upon
3 the election of such program under subsection (d) to
4 receive payments directly. No payment may be made
5 out of the special fund described in such paragraph
6 with respect to reimbursement made for services
7 provided by such program during the period of such
8 election.

9 “(d) DIRECT BILLING.—

10 “(1) IN GENERAL.—Subject to complying with
11 the requirements of paragraph (2), a tribal health
12 program may elect to directly bill for, and receive
13 payment for, health care items and services provided
14 by such program for which payment is made under
15 title XVIII, XIX, or XXI of the Social Security Act
16 or from any other third party payor.

17 “(2) DIRECT REIMBURSEMENT.—

18 “(A) USE OF FUNDS.—Each tribal health
19 program making the election described in para-
20 graph (1) with respect to a program under a
21 title of the Social Security Act shall be reim-
22 bursed directly by that program for items and
23 services furnished without regard to subsection
24 (c)(1), except that all amounts so reimbursed
25 shall be used by the tribal health program for

1 the purpose of making any improvements in fa-
2 cilities of the tribal health program that may be
3 necessary to achieve or maintain compliance
4 with the conditions and requirements applicable
5 generally to such items and services under the
6 program under such title and to provide addi-
7 tional health care services, improvements in
8 health care facilities and tribal health pro-
9 grams, any health care-related purpose (includ-
10 ing coverage for a service or service within a
11 contract health service delivery area or any por-
12 tion of a contract health service delivery area
13 that would otherwise be provided as a contract
14 health service), or otherwise to achieve the ob-
15 jectives provided in section 3 of this Act.

16 “(B) AUDITS.—The amounts paid to a
17 tribal health program making the election de-
18 scribed in paragraph (1) with respect to a pro-
19 gram under title XVIII, XIX, or XXI of the So-
20 cial Security Act shall be subject to all auditing
21 requirements applicable to the program under
22 such title, as well as all auditing requirements
23 applicable to programs administered by an In-
24 dian health program. Nothing in the preceding
25 sentence shall be construed as limiting the ap-

1 plication of auditing requirements applicable to
2 amounts paid under title XVIII, XIX, or XXI
3 of the Social Security Act.

4 “(C) IDENTIFICATION OF SOURCE OF PAY-
5 MENTS.—Any tribal health program that re-
6 ceives reimbursements or payments under title
7 XVIII, XIX, or XXI of the Social Security Act
8 shall provide to the Service a list of each pro-
9 vider enrollment number (or other identifier)
10 under which such program receives such reim-
11 bursements or payments.

12 “(3) EXAMINATION AND IMPLEMENTATION OF
13 CHANGES.—

14 “(A) IN GENERAL.—The Secretary, acting
15 through the Service and with the assistance of
16 the Administrator of the Centers for Medicare
17 & Medicaid Services, shall examine on an ongo-
18 ing basis and implement any administrative
19 changes that may be necessary to facilitate di-
20 rect billing and reimbursement under the pro-
21 gram established under this subsection, includ-
22 ing any agreements with States that may be
23 necessary to provide for direct billing under a
24 program under title XIX or XXI of the Social
25 Security Act.

1 “(B) COORDINATION OF INFORMATION.—
2 The Service shall provide the Administrator of
3 the Centers for Medicare & Medicaid Services
4 with copies of the lists submitted to the Service
5 under paragraph (2)(C), enrollment data re-
6 garding patients served by the Service (and by
7 tribal health programs, to the extent such data
8 is available to the Service), and such other in-
9 formation as the Administrator may require for
10 purposes of administering title XVIII, XIX, or
11 XXI of the Social Security Act.

12 “(4) WITHDRAWAL FROM PROGRAM.—A tribal
13 health program that bills directly under the program
14 established under this subsection may withdraw
15 from participation in the same manner and under
16 the same conditions that an Indian tribe or tribal or-
17 ganization may retrocede a contracted program to
18 the Secretary under the authority of the Indian Self-
19 Determination and Education Assistance Act (25
20 U.S.C. 450 et seq.). All cost accounting and billing
21 authority under the program established under this
22 subsection shall be returned to the Secretary upon
23 the Secretary’s acceptance of the withdrawal of par-
24 ticipation in this program.

1 “(5) TERMINATION FOR FAILURE TO COMPLY
2 WITH REQUIREMENTS.—The Secretary may termi-
3 nate the participation of a tribal health program or
4 in the direct billing program established under this
5 subsection if the Secretary determines that the pro-
6 gram has failed to comply with the requirements of
7 paragraph (2). The Secretary shall provide a tribal
8 health program with notice of a determination that
9 the program has failed to comply with any such re-
10 quirement and a reasonable opportunity to correct
11 such noncompliance prior to terminating the pro-
12 gram’s participation in the direct billing program es-
13 tablished under this subsection.

14 “(e) RELATED PROVISIONS UNDER THE SOCIAL SE-
15 CURITY ACT.—For provisions related to subsections (c)
16 and (d), see sections 1880, 1911, and 2107(e)(1)(D) of
17 the Social Security Act.”.

18 **SEC. 152. PURCHASING HEALTH CARE COVERAGE.**

19 Section 402 of the Indian Health Care Improvement
20 Act (25 U.S.C. 1642) is amended to read as follows:

21 **“SEC. 402. PURCHASING HEALTH CARE COVERAGE.**

22 “(a) IN GENERAL.—Insofar as amounts are made
23 available under law (including a provision of the Social
24 Security Act, the Indian Self-Determination and Edu-
25 cation Assistance Act (25 U.S.C. 450 et seq.), or other

1 law, other than under section 404) to Indian tribes, tribal
2 organizations, and urban Indian organizations for health
3 benefits for Service beneficiaries, Indian tribes, tribal or-
4 ganizations, and urban Indian organizations may use such
5 amounts to purchase health benefits coverage (including
6 coverage for a service, or service within a contract health
7 service delivery area, or any portion of a contract health
8 service delivery area that would otherwise be provided as
9 a contract health service) for such beneficiaries in any
10 manner, including through—

11 “(1) a tribally owned and operated health care
12 plan;

13 “(2) a State or locally authorized or licensed
14 health care plan;

15 “(3) a health insurance provider or managed
16 care organization;

17 “(4) a self-insured plan; or

18 “(5) a high deductible or health savings account
19 plan.

20 “(b) FINANCIAL NEED.—The purchase of coverage
21 under subsection (a) by an Indian tribe, tribal organiza-
22 tion, or urban Indian organization may be based on the
23 financial needs of such beneficiaries (as determined by the
24 1 or more Indian tribes being served based on a schedule

1 of income levels developed or implemented by such 1 ore
2 more Indian tribes).

3 “(c) EXPENSES FOR SELF-INSURED PLAN.—In the
4 case of a self-insured plan under subsection (a)(4), the
5 amounts may be used for expenses of operating the plan,
6 including administration and insurance to limit the finan-
7 cial risks to the entity offering the plan.

8 “(d) CONSTRUCTION.—Nothing in this section shall
9 be construed as affecting the use of any amounts not re-
10 ferred to in subsection (a).”.

11 **SEC. 153. GRANTS TO AND CONTRACTS WITH THE SERVICE,**
12 **INDIAN TRIBES, TRIBAL ORGANIZATIONS,**
13 **AND URBAN INDIAN ORGANIZATIONS TO FA-**
14 **CILITATE OUTREACH, ENROLLMENT, AND**
15 **COVERAGE OF INDIANS UNDER SOCIAL SECU-**
16 **RITY ACT HEALTH BENEFIT PROGRAMS AND**
17 **OTHER HEALTH BENEFITS PROGRAMS.**

18 Section 404 of the Indian Health Care Improvement
19 Act (25 U.S.C. 1644) is amended to read as follows:

1 **“SEC. 404. GRANTS TO AND CONTRACTS WITH THE SERV-**
2 **ICE, INDIAN TRIBES, TRIBAL ORGANIZA-**
3 **TIONS, AND URBAN INDIAN ORGANIZATIONS**
4 **TO FACILITATE OUTREACH, ENROLLMENT,**
5 **AND COVERAGE OF INDIANS UNDER SOCIAL**
6 **SECURITY ACT HEALTH BENEFIT PROGRAMS**
7 **AND OTHER HEALTH BENEFITS PROGRAMS.**

8 “(a) INDIAN TRIBES AND TRIBAL ORGANIZA-
9 TIONS.—The Secretary, acting through the Service, shall
10 make grants to or enter into contracts with Indian tribes
11 and tribal organizations to assist such tribes and tribal
12 organizations in establishing and administering programs
13 on or near reservations and trust lands, including pro-
14 grams to provide outreach and enrollment through video,
15 electronic delivery methods, or telecommunication devices
16 that allow real-time or time-delayed communication be-
17 tween individual Indians and the benefit program, to as-
18 sist individual Indians—

19 “(1) to enroll for benefits under a program es-
20 tablished under title XVIII, XIX, or XXI of the So-
21 cial Security Act and other health benefits pro-
22 grams; and

23 “(2) with respect to such programs for which
24 the charging of premiums and cost sharing is not
25 prohibited under such programs, to pay premiums or
26 cost sharing for coverage for such benefits, which

1 may be based on financial need (as determined by
2 the Indian tribe or tribes or tribal organizations
3 being served based on a schedule of income levels de-
4 veloped or implemented by such tribe, tribes, or trib-
5 al organizations).

6 “(b) CONDITIONS.—The Secretary, acting through
7 the Service, shall place conditions as deemed necessary to
8 effect the purpose of this section in any grant or contract
9 which the Secretary makes with any Indian tribe or tribal
10 organization pursuant to this section. Such conditions
11 shall include requirements that the Indian tribe or tribal
12 organization successfully undertake—

13 “(1) to determine the population of Indians eli-
14 gible for the benefits described in subsection (a);

15 “(2) to educate Indians with respect to the ben-
16 efits available under the respective programs;

17 “(3) to provide transportation for such indi-
18 vidual Indians to the appropriate offices for enroll-
19 ment or applications for such benefits; and

20 “(4) to develop and implement methods of im-
21 proving the participation of Indians in receiving ben-
22 efits under such programs.

23 “(c) APPLICATION TO URBAN INDIAN ORGANIZA-
24 TIONS.—

1 “(1) IN GENERAL.—The provisions of sub-
2 section (a) shall apply with respect to grants and
3 other funding to urban Indian organizations with re-
4 spect to populations served by such organizations in
5 the same manner they apply to grants and contracts
6 with Indian tribes and tribal organizations with re-
7 spect to programs on or near reservations.

8 “(2) REQUIREMENTS.—The Secretary shall in-
9 clude in the grants or contracts made or provided
10 under paragraph (1) requirements that are—

11 “(A) consistent with the requirements im-
12 posed by the Secretary under subsection (b);

13 “(B) appropriate to urban Indian organi-
14 zations and urban Indians; and

15 “(C) necessary to effect the purposes of
16 this section.

17 “(d) FACILITATING COOPERATION.—The Secretary,
18 acting through the Centers for Medicare & Medicaid Serv-
19 ices, shall develop and disseminate best practices that will
20 serve to facilitate cooperation with, and agreements be-
21 tween, States and the Service, Indian tribes, tribal organi-
22 zations, or urban Indian organizations with respect to the
23 provision of health care items and services to Indians
24 under the programs established under title XVIII, XIX,
25 or XXI of the Social Security Act.

1 “(e) AGREEMENTS RELATING TO IMPROVING EN-
2 ROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT
3 HEALTH BENEFITS PROGRAMS.—For provisions relating
4 to agreements of the Secretary, acting through the Serv-
5 ice, for the collection, preparation, and submission of ap-
6 plications by Indians for assistance under the Medicaid
7 and children’s health insurance programs established
8 under titles XIX and XXI of the Social Security Act, and
9 benefits under the Medicare program established under
10 title XVIII of such Act, see subsections (a) and (b) of sec-
11 tion 1139 of the Social Security Act.

12 “(f) DEFINITION OF PREMIUMS AND COST SHAR-
13 ING.—In this section:

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

16 “(2) COST SHARING.—The term ‘cost sharing’
17 includes any deduction, deductible, copayment, coin-
18 surance, or similar charge.”.

19 **SEC. 154. SHARING ARRANGEMENTS WITH FEDERAL AGEN-**
20 **CIES.**

21 Section 405 of the Indian Health Care Improvement
22 Act (25 U.S.C. 1645) is amended to read as follows:

23 **“SEC. 405. SHARING ARRANGEMENTS WITH FEDERAL AGEN-**
24 **CIES.**

25 “(a) AUTHORITY.—

1 “(1) IN GENERAL.—The Secretary may enter
2 into (or expand) arrangements for the sharing of
3 medical facilities and services between the Service,
4 Indian tribes, and tribal organizations and the De-
5 partment of Veterans Affairs and the Department of
6 Defense.

7 “(2) CONSULTATION BY SECRETARY RE-
8 QUIRED.—The Secretary may not finalize any ar-
9 rangement between the Service and a Department
10 described in paragraph (1) without first consulting
11 with the Indian tribes which will be significantly af-
12 fected by the arrangement.

13 “(b) LIMITATIONS.—The Secretary shall not take
14 any action under this section or under subchapter IV of
15 chapter 81 of title 38, United States Code, which would
16 impair—

17 “(1) the priority access of any Indian to health
18 care services provided through the Service and the
19 eligibility of any Indian to receive health services
20 through the Service;

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

23 “(3) the priority access of any veteran to health
24 care services provided by the Department of Vet-
25 erans Affairs;

1 “(4) the quality of health care services provided
2 by the Department of Veterans Affairs or the De-
3 partment of Defense; or

4 “(5) the eligibility of any Indian who is a vet-
5 eran to receive health services through the Depart-
6 ment of Veterans Affairs.

7 “(c) REIMBURSEMENT.—The Service, Indian tribe,
8 or tribal organization shall be reimbursed by the Depart-
9 ment of Veterans Affairs or the Department of Defense
10 (as the case may be) where services are provided through
11 the Service, an Indian tribe, or a tribal organization to
12 beneficiaries eligible for services from either such Depart-
13 ment, notwithstanding any other provision of law.

14 “(d) CONSTRUCTION.—Nothing in this section may
15 be construed as creating any right of a non-Indian veteran
16 to obtain health services from the Service.”.

17 **SEC. 155. ELIGIBLE INDIAN VETERAN SERVICES.**

18 Title IV of the Indian Health Care Improvement Act
19 (25 U.S.C. 1641 et seq.) (as amended by section 101(b))
20 is amended by adding at the end the following:

21 **“SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.**

22 “(a) FINDINGS; PURPOSE.—

23 “(1) FINDINGS.—Congress finds that—

24 “(A) collaborations between the Secretary
25 and the Secretary of Veterans Affairs regarding

1 the treatment of Indian veterans at facilities of
2 the Service should be encouraged to the max-
3 imum extent practicable; and

4 “(B) increased enrollment for services of
5 the Department of Veterans Affairs by veterans
6 who are members of Indian tribes should be en-
7 couraged to the maximum extent practicable.

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

15 “(b) DEFINITIONS.—In this section:

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

20 “(A) authorized under the laws adminis-
21 tered by the Secretary of Veterans Affairs; and

22 “(B) administered at a facility of the Serv-
23 ice (including a facility operated by an Indian
24 tribe or tribal organization through a contract
25 or compact with the Service under the Indian

1 Self-Determination and Education Assistance
2 Act (25 U.S.C. 450 et seq.)) pursuant to a local
3 memorandum of understanding.

4 “(2) LOCAL MEMORANDUM OF UNDER-
5 STANDING.—The term ‘local memorandum of under-
6 standing’ means a memorandum of understanding
7 between the Secretary (or a designee, including the
8 director of any area office of the Service) and the
9 Secretary of Veterans Affairs (or a designee) to im-
10 plement the document entitled ‘Memorandum of Un-
11 derstanding Between the VA/Veterans Health Ad-
12 ministration And HHS/Indian Health Service’ and
13 dated February 25, 2003 (relating to cooperation
14 and resource sharing between the Veterans Health
15 Administration and Indian Health Service).

16 “(c) ELIGIBLE INDIAN VETERANS EXPENSES.—

17 “(1) IN GENERAL.—Notwithstanding any other
18 provision of law, the Secretary shall provide for vet-
19 eran-related expenses incurred by eligible Indian vet-
20 erans as described in subsection (b)(1)(B).

21 “(2) METHOD OF PAYMENT.—The Secretary
22 shall establish such guidelines as the Secretary de-
23 termines to be appropriate regarding the method of
24 payments to the Secretary of Veterans Affairs under
25 paragraph (1).

1 “(d) TRIBAL APPROVAL OF MEMORANDA.—In nego-
2 tiating a local memorandum of understanding with the
3 Secretary of Veterans Affairs regarding the provision of
4 services to eligible Indian veterans, the Secretary shall
5 consult with each Indian tribe that would be affected by
6 the local memorandum of understanding.

7 “(e) FUNDING.—

8 “(1) TREATMENT.—Expenses incurred by the
9 Secretary in carrying out subsection (c)(1) shall not
10 be considered to be Contract Health Service ex-
11 penses.

12 “(2) USE OF FUNDS.—Of funds made available
13 to the Secretary in appropriations Acts for the Serv-
14 ice (excluding funds made available for facilities,
15 Contract Health Services, or contract support costs),
16 the Secretary shall use such sums as are necessary
17 to carry out this section.”.

18 **SEC. 156. NONDISCRIMINATION UNDER FEDERAL HEALTH**
19 **CARE PROGRAMS IN QUALIFICATIONS FOR**
20 **REIMBURSEMENT FOR SERVICES.**

21 Title IV of the Indian Health Care Improvement Act
22 (25 U.S.C. 1641 et seq.) (as amended by section 155) is
23 amended by adding at the end the following:

1 **“SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH**
2 **CARE PROGRAMS IN QUALIFICATIONS FOR**
3 **REIMBURSEMENT FOR SERVICES.**

4 “(a) REQUIREMENT TO SATISFY GENERALLY APPLI-
5 CABLE PARTICIPATION REQUIREMENTS.—

6 “(1) IN GENERAL.—A Federal health care pro-
7 gram must accept an entity that is operated by the
8 Service, an Indian tribe, tribal organization, or
9 urban Indian organization as a provider eligible to
10 receive payment under the program for health care
11 services furnished to an Indian on the same basis as
12 any other provider qualified to participate as a pro-
13 vider of health care services under the program if
14 the entity meets generally applicable State or other
15 requirements for participation as a provider of
16 health care services under the program.

17 “(2) SATISFACTION OF STATE OR LOCAL LICEN-
18 SURE OR RECOGNITION REQUIREMENTS.—Any re-
19 quirement for participation as a provider of health
20 care services under a Federal health care program
21 that an entity be licensed or recognized under the
22 State or local law where the entity is located to fur-
23 nish health care services shall be deemed to have
24 been met in the case of an entity operated by the
25 Service, an Indian tribe, tribal organization, or
26 urban Indian organization if the entity meets all the

1 applicable standards for such licensure or recogni-
2 tion, regardless of whether the entity obtains a li-
3 cense or other documentation under such State or
4 local law. In accordance with section 221, the ab-
5 sence of the licensure of a health professional em-
6 ployed by such an entity under the State or local law
7 where the entity is located shall not be taken into
8 account for purposes of determining whether the en-
9 tity meets such standards, if the professional is li-
10 censed in another State.

11 “(b) APPLICATION OF EXCLUSION FROM PARTICIPA-
12 TION IN FEDERAL HEALTH CARE PROGRAMS.—

13 “(1) EXCLUDED ENTITIES.—No entity operated
14 by the Service, an Indian tribe, tribal organization,
15 or urban Indian organization that has been excluded
16 from participation in any Federal health care pro-
17 gram or for which a license is under suspension or
18 has been revoked by the State where the entity is lo-
19 cated shall be eligible to receive payment or reim-
20 bursement under any such program for health care
21 services furnished to an Indian.

22 “(2) EXCLUDED INDIVIDUALS.—No individual
23 who has been excluded from participation in any
24 Federal health care program or whose State license
25 is under suspension shall be eligible to receive pay-

1 ment or reimbursement under any such program for
2 health care services furnished by that individual, di-
3 rectly or through an entity that is otherwise eligible
4 to receive payment for health care services, to an In-
5 dian.

6 “(3) FEDERAL HEALTH CARE PROGRAM DE-
7 FINED.—In this subsection, the term, ‘Federal
8 health care program’ has the meaning given that
9 term in section 1128B(f) of the Social Security Act
10 (42 U.S.C. 1320a–7b(f)), except that, for purposes
11 of this subsection, such term shall include the health
12 insurance program under chapter 89 of title 5,
13 United States Code.

14 “(c) RELATED PROVISIONS.—For provisions related
15 to nondiscrimination against providers operated by the
16 Service, an Indian tribe, tribal organization, or urban In-
17 dian organization, see section 1139(c) of the Social Secu-
18 rity Act (42 U.S.C. 1320b–9(c)).”.

19 **SEC. 157. ACCESS TO FEDERAL INSURANCE.**

20 Title IV of the Indian Health Care Improvement Act
21 (25 U.S.C. 1641 et seq.) (as amended by section 156) is
22 amended by adding at the end the following:

23 **“SEC. 409. ACCESS TO FEDERAL INSURANCE.**

24 “Notwithstanding the provisions of title 5, United
25 States Code, Executive order, or administrative regula-

1 tion, an Indian tribe or tribal organization carrying out
2 programs under the Indian Self-Determination and Edu-
3 cation Assistance Act (25 U.S.C. 450 et seq.) or an urban
4 Indian organization carrying out programs under title V
5 of this Act shall be entitled to purchase coverage, rights,
6 and benefits for the employees of such Indian tribe or trib-
7 al organization, or urban Indian organization, under chap-
8 ter 89 of title 5, United States Code, and chapter 87 of
9 such title if necessary employee deductions and agency
10 contributions in payment for the coverage, rights, and ben-
11 efits for the period of employment with such Indian tribe
12 or tribal organization, or urban Indian organization, are
13 currently deposited in the applicable Employee's Fund
14 under such title.”.

15 **SEC. 158. GENERAL EXCEPTIONS.**

16 Title IV of the Indian Health Care Improvement Act
17 (25 U.S.C. 1641 et seq.) (as amended by section 157) is
18 amended by adding at the end the following:

19 **“SEC. 410. GENERAL EXCEPTIONS.**

20 “The requirements of this title shall not apply to any
21 excepted benefits described in paragraph (1)(A) or (3) of
22 section 2791(c) of the Public Health Service Act (42
23 U.S.C. 300gg–91).”.

1 **SEC. 159. NAVAJO NATION MEDICAID AGENCY FEASIBILITY**
2 **STUDY.**

3 Title IV of the Indian Health Care Improvement Act
4 (25 U.S.C. 1641 et seq.) (as amended by section 158) is
5 amended by adding at the end the following:

6 **“SEC. 411. NAVAJO NATION MEDICAID AGENCY FEASI-**
7 **BILITY STUDY.**

8 “(a) **STUDY.**—The Secretary shall conduct a study
9 to determine the feasibility of treating the Navajo Nation
10 as a State for the purposes of title XIX of the Social Secu-
11 rity Act, to provide services to Indians living within the
12 boundaries of the Navajo Nation through an entity estab-
13 lished having the same authority and performing the same
14 functions as single-State medicaid agencies responsible for
15 the administration of the State plan under title XIX of
16 the Social Security Act.

17 “(b) **CONSIDERATIONS.**—In conducting the study,
18 the Secretary shall consider the feasibility of—

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

1 “(2) providing assistance to the Navajo Nation
2 in the development and implementation of such enti-
3 ty for the administration, eligibility, payment, and
4 delivery of medical assistance under title XIX of the
5 Social Security Act;

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

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

16 “(c) REPORT.—Not later than 3 years after the date
17 of enactment of the Indian Health Care Improvement Re-
18 authorization and Extension Act of 2009, the Secretary
19 shall submit to the Committee on Indian Affairs and Com-
20 mittee on Finance of the Senate and the Committee on
21 Natural Resources and Committee on Energy and Com-
22 merce of the House of Representatives a report that in-
23 cludes—

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

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

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

11 “(4) legislative actions that would be required
12 to authorize the establishment of such entity if such
13 entity is determined by the Secretary to be fea-
14 sible.”.

15 **Subtitle E—Health Services for** 16 **Urban Indians**

17 **SEC. 161. FACILITIES RENOVATION.**

18 Section 509 of the Indian Health Care Improvement
19 Act (25 U.S.C. 1659) is amended by inserting “or con-
20 struction or expansion of facilities” after “renovations to
21 facilities”.

22 **SEC. 162. TREATMENT OF CERTAIN DEMONSTRATION** 23 **PROJECTS.**

24 Section 512 of the Indian Health Care Improvement
25 Act (25 U.S.C. 1660b) is amended to read as follows:

1 **“SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION**
2 **PROJECTS.**

3 “Notwithstanding any other provision of law, the
4 Tulsa Clinic and Oklahoma City Clinic demonstration
5 projects shall—

6 “(1) be permanent programs within the Serv-
7 ice’s direct care program;

8 “(2) continue to be treated as Service units and
9 operating units in the allocation of resources and co-
10 ordination of care; and

11 “(3) continue to meet the requirements and
12 definitions of an urban Indian organization in this
13 Act, and shall not be subject to the provisions of the
14 Indian Self-Determination and Education Assistance
15 Act (25 U.S.C. 450 et seq.).”.

16 **SEC. 163. REQUIREMENT TO CONFER WITH URBAN INDIAN**
17 **ORGANIZATIONS.**

18 (a) CONFERRING WITH URBAN INDIAN ORGANIZA-
19 TIONS.—Title V of the Indian Health Care Improvement
20 Act (25 U.S.C. 1651 et seq.) (as amended by section
21 101(b)) is amended by adding at the end the following:

22 **“SEC. 514. CONFERRING WITH URBAN INDIAN ORGANIZA-**
23 **TIONS.**

24 “(a) DEFINITION OF CONFER.—In this section, the
25 term ‘confer’ means to engage in an open and free ex-
26 change of information and opinions that—

1 retary enters with, or in any grant the Secretary makes
2 to, any urban Indian organization pursuant to this title.”.

3 **SEC. 164. EXPANDED PROGRAM AUTHORITY FOR URBAN IN-**
4 **DIAN ORGANIZATIONS.**

5 Title V of the Indian Health Care Improvement Act
6 (25 U.S.C. 1651 et seq.) (as amended by section 163(a))
7 is amended by adding at the end the following:

8 **“SEC. 515. EXPANDED PROGRAM AUTHORITY FOR URBAN**
9 **INDIAN ORGANIZATIONS.**

10 “Notwithstanding any other provision of this Act, the
11 Secretary, acting through the Service, is authorized to es-
12 tablish programs, including programs for awarding grants,
13 for urban Indian organizations that are identical to any
14 programs established pursuant to sections 218, 702, and
15 708(g).”.

16 **SEC. 165. COMMUNITY HEALTH REPRESENTATIVES.**

17 Title V of the Indian Health Care Improvement Act
18 (25 U.S.C. 1651 et seq.) (as amended by section 164) is
19 amended by adding at the end the following:

20 **“SEC. 516. COMMUNITY HEALTH REPRESENTATIVES.**

21 “The Secretary, acting through the Service, may
22 enter into contracts with, and make grants to, urban In-
23 dian organizations for the employment of Indians trained
24 as health service providers through the Community Health
25 Representative Program under section 107 in the provi-

1 sion of health care, health promotion, and disease preven-
2 tion services to urban Indians.”.

3 **SEC. 166. USE OF FEDERAL GOVERNMENT FACILITIES AND**
4 **SOURCES OF SUPPLY; HEALTH INFORMATION**
5 **TECHNOLOGY.**

6 Title V of the Indian Health Care Improvement Act
7 (25 U.S.C. 1651 et seq.) (as amended by section 165) is
8 amended by adding at the end the following:

9 **“SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND**
10 **SOURCES OF SUPPLY.**

11 “(a) IN GENERAL.—The Secretary may permit an
12 urban Indian organization that has entered into a contract
13 or received a grant pursuant to this title, in carrying out
14 the contract or grant, to use, in accordance with such
15 terms and conditions for use and maintenance as are
16 agreed on by the Secretary and the urban Indian organiza-
17 tions—

18 “(1) any existing facility under the jurisdiction
19 of the Secretary;

20 “(2) all equipment contained in or pertaining to
21 such an existing facility; and

22 “(3) any other personal property of the Federal
23 Government under the jurisdiction of the Secretary.

24 “(b) DONATIONS.—Subject to subsection (d), the
25 Secretary may donate to an urban Indian organization

1 that has entered into a contract or received a grant pursu-
2 ant to this title any personal or real property determined
3 to be excess to the needs of the Service or the General
4 Services Administration for the purposes of carrying out
5 the contract or grant.

6 “(c) ACQUISITION OF PROPERTY.—The Secretary
7 may acquire excess or surplus personal or real property
8 of the Federal Government for donation, subject to sub-
9 section (d), to an urban Indian organization that has en-
10 tered into a contract or received a grant pursuant to this
11 title if the Secretary determines that the property is ap-
12 propriate for use by the urban Indian organization for
13 purposes of the contract or grant.

14 “(d) PRIORITY.—If the Secretary receives from an
15 urban Indian organization or an Indian tribe or tribal or-
16 ganization a request for a specific item of personal or real
17 property described in subsection (b) or (c), the Secretary
18 shall give priority to the request for donation to the Indian
19 tribe or tribal organization, if the Secretary receives the
20 request from the Indian tribe or tribal organization before
21 the earlier of—

22 “(1) the date on which the Secretary transfers
23 title to the property to the urban Indian organiza-
24 tion; and

1 “(2) the date on which the Secretary transfers
2 the property physically to the urban Indian organi-
3 zation.

4 “(e) EXECUTIVE AGENCY STATUS.—For purposes of
5 section 501(a) of title 40, United States Code, an urban
6 Indian organization that has entered into a contract or
7 received a grant pursuant to this title may be considered
8 to be an Executive agency in carrying out the contract
9 or grant.

10 **“SEC. 518. HEALTH INFORMATION TECHNOLOGY.**

11 “The Secretary, acting through the Service, may
12 make grants to urban Indian organizations under this title
13 for the development, adoption, and implementation of
14 health information technology (as defined in section 3000
15 of the Public Health Service Act (42 U.S.C. 300jj)), tele-
16 medicine services development, and related infrastruc-
17 ture.”.

18 **Subtitle F—Organizational**
19 **Improvements**

20 **SEC. 171. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
21 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
22 **SERVICE.**

23 Section 601 of the Indian Health Care Improvement
24 Act (25 U.S.C. 1661) is amended to read as follows:

1 **“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
2 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
3 **SERVICE.**

4 “(a) ESTABLISHMENT.—

5 “(1) IN GENERAL.—In order to more effectively
6 and efficiently carry out the responsibilities, authori-
7 ties, and functions of the United States to provide
8 health care services to Indians and Indian tribes, as
9 are or may be hereafter provided by Federal statute
10 or treaties, there is established within the Public
11 Health Service of the Department the Indian Health
12 Service.

13 “(2) DIRECTOR.—The Service shall be adminis-
14 tered by a Director, who shall be appointed by the
15 President, by and with the advice and consent of the
16 Senate. The Director shall report to the Secretary.
17 Effective with respect to an individual appointed by
18 the President, by and with the advice and consent
19 of the Senate, after January 1, 2008, the term of
20 service of the Director shall be 4 years. A Director
21 may serve more than 1 term.

22 “(3) INCUMBENT.—The individual serving in
23 the position of Director of the Service on the day be-
24 fore the date of enactment of the Indian Health
25 Care Improvement Reauthorization and Extension
26 Act of 2009 shall serve as Director.

1 “(4) **ADVOCACY AND CONSULTATION.**—The po-
2 sition of Director is established to, in a manner con-
3 sistent with the government-to-government relation-
4 ship between the United States and Indian Tribes—

5 “(A) facilitate advocacy for the develop-
6 ment of appropriate Indian health policy; and

7 “(B) promote consultation on matters re-
8 lating to Indian health.

9 “(b) **AGENCY.**—The Service shall be an agency within
10 the Public Health Service of the Department, and shall
11 not be an office, component, or unit of any other agency
12 of the Department.

13 “(c) **DUTIES.**—The Director shall—

14 “(1) perform all functions that were, on the day
15 before the date of enactment of the Indian Health
16 Care Improvement Reauthorization and Extension
17 Act of 2009, carried out by or under the direction
18 of the individual serving as Director of the Service
19 on that day;

20 “(2) perform all functions of the Secretary re-
21 lating to the maintenance and operation of hospital
22 and health facilities for Indians and the planning
23 for, and provision and utilization of, health services
24 for Indians, including by ensuring that all agency di-
25 rectors, managers, and chief executive officers have

1 appropriate and adequate training, experience, skill
2 levels, knowledge, abilities, and education (including
3 continuing training requirements) to competently
4 fulfill the duties of the positions and the mission of
5 the Service;

6 “(3) administer all health programs under
7 which health care is provided to Indians based upon
8 their status as Indians which are administered by
9 the Secretary, including programs under—

10 “(A) this Act;

11 “(B) the Act of November 2, 1921 (25
12 U.S.C. 13);

13 “(C) the Act of August 5, 1954 (42 U.S.C.
14 2001 et seq.);

15 “(D) the Act of August 16, 1957 (42
16 U.S.C. 2005 et seq.); and

17 “(E) the Indian Self-Determination and
18 Education Assistance Act (25 U.S.C. 450 et
19 seq.);

20 “(4) administer all scholarship and loan func-
21 tions carried out under title I;

22 “(5) directly advise the Secretary concerning
23 the development of all policy- and budget-related
24 matters affecting Indian health;

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

5 “(7) advise each Assistant Secretary of the De-
6 partment concerning matters of Indian health with
7 respect to which that Assistant Secretary has au-
8 thority and responsibility;

9 “(8) advise the heads of other agencies and pro-
10 grams of the Department concerning matters of In-
11 dian health with respect to which those heads have
12 authority and responsibility;

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

15 “(10) perform such other functions as the Sec-
16 retary may designate.

17 “(d) AUTHORITY.—

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

20 “(A) except to the extent provided for in
21 paragraph (2), to appoint and compensate em-
22 ployees for the Service in accordance with title
23 5, United States Code;

1 “(B) to enter into contracts for the pro-
2 curement of goods and services to carry out the
3 functions of the Service; and

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

6 “(2) PERSONNEL ACTIONS.—Notwithstanding
7 any other provision of law, the provisions of section
8 12 of the Act of June 18, 1934 (48 Stat. 986; 25
9 U.S.C. 472), shall apply to all personnel actions
10 taken with respect to new positions created within
11 the Service as a result of its establishment under
12 subsection (a).”.

13 **SEC. 172. OFFICE OF DIRECT SERVICE TRIBES.**

14 Title VI of the Indian Health Care Improvement Act
15 (25 U.S.C. 1661 et seq.) (as amended by section 101(b))
16 is amended by adding at the end the following:

17 **“SEC. 603. OFFICE OF DIRECT SERVICE TRIBES.**

18 “(a) ESTABLISHMENT.—There is established within
19 the Service an office, to be known as the ‘Office of Direct
20 Service Tribes’.

21 “(b) TREATMENT.—The Office of Direct Service
22 Tribes shall be located in the Office of the Director.

23 “(c) DUTIES.—The Office of Direct Service Tribes
24 shall be responsible for—

1 “(1) providing Service-wide leadership, guidance
2 and support for direct service tribes to include stra-
3 tegic planning and program evaluation;

4 “(2) ensuring maximum flexibility to tribal
5 health and related support systems for Indian bene-
6 ficiaries;

7 “(3) serving as the focal point for consultation
8 and participation between direct service tribes and
9 organizations and the Service in the development of
10 Service policy;

11 “(4) holding no less than biannual consultations
12 with direct service tribes in appropriate locations to
13 gather information and aid in the development of
14 health policy; and

15 “(5) directing a national program and providing
16 leadership and advocacy in the development of
17 health policy, program management, budget formu-
18 lation, resource allocation, and delegation support
19 for direct service tribes.”.

20 **SEC. 173. NEVADA AREA OFFICE.**

21 Title VI of the Indian Health Care Improvement Act
22 (25 U.S.C. 1661 et seq.) (as amended by section 172) is
23 amended by adding at the end the following:

1 **“SEC. 604. NEVADA AREA OFFICE.**

2 “(a) IN GENERAL.—Not later than 1 year after the
3 date of enactment of this section, in a manner consistent
4 with the tribal consultation policy of the Service, the Sec-
5 retary shall submit to Congress a plan describing the man-
6 ner and schedule by which an area office, separate and
7 distinct from the Phoenix Area Office of the Service, can
8 be established in the State of Nevada.

9 “(b) FAILURE TO SUBMIT PLAN.—

10 “(1) DEFINITION OF OPERATIONS FUNDS.—In
11 this subsection, the term ‘operations funds’ means
12 only the funds used for—

13 “(A) the administration of services, includ-
14 ing functional expenses such as overtime, per-
15 sonnel salaries, and associated benefits; or

16 “(B) related tasks that directly affect the
17 operations described in subparagraph (A).

18 “(2) WITHHOLDING OF FUNDS.—If the Sec-
19 retary fails to submit a plan in accordance with sub-
20 section (a), the Secretary shall withhold the oper-
21 ations funds reserved for the Office of the Director,
22 subject to the condition that the withholding shall
23 not adversely impact the capacity of the Service to
24 deliver health care services.

25 “(3) RESTORATION.—The operations funds
26 withheld pursuant to paragraph (2) may be restored,

1 at the discretion of the Secretary, to the Office of
2 the Director on achievement by that Office of com-
3 pliance with this section.”.

4 **Subtitle G—Behavioral Health**
5 **Programs**

6 **SEC. 181. BEHAVIORAL HEALTH PROGRAMS.**

7 Title VII of the Indian Health Care Improvement Act
8 (25 U.S.C. 1665 et seq.) is amended to read as follows:

9 **“TITLE VII—BEHAVIORAL**
10 **HEALTH PROGRAMS**

11 **“Subtitle A—General Programs**

12 **“SEC. 701. DEFINITIONS.**

13 “In this subtitle:

14 “(1) **ALCOHOL-RELATED**
15 **NEURODEVELOPMENTAL DISORDERS; ARND.**—The
16 term ‘alcohol-related neurodevelopmental disorders’
17 or ‘ARND’ means, with a history of maternal alco-
18 hol consumption during pregnancy, central nervous
19 system abnormalities, which may range from minor
20 intellectual deficits and developmental delays to
21 mental retardation. ARND children may have behav-
22 ioral problems, learning disabilities, problems with
23 executive functioning, and attention disorders. The
24 neurological defects of ARND may be as severe as
25 FAS, but facial anomalies and other physical char-

1 acteristics are not present in ARND, thus making
2 diagnosis difficult.

3 “(2) ASSESSMENT.—The term ‘assessment’
4 means the systematic collection, analysis, and dis-
5 semination of information on health status, health
6 needs, and health problems.

7 “(3) BEHAVIORAL HEALTH AFTERCARE.—The
8 term ‘behavioral health aftercare’ includes those ac-
9 tivities and resources used to support recovery fol-
10 lowing inpatient, residential, intensive substance
11 abuse, or mental health outpatient or outpatient
12 treatment. The purpose is to help prevent or deal
13 with relapse by ensuring that by the time a client or
14 patient is discharged from a level of care, such as
15 outpatient treatment, an aftercare plan has been de-
16 veloped with the client. An aftercare plan may use
17 such resources as a community-based therapeutic
18 group, transitional living facilities, a 12-step spon-
19 sor, a local 12-step or other related support group,
20 and other community-based providers.

21 “(4) DUAL DIAGNOSIS.—The term ‘dual diag-
22 nosis’ means coexisting substance abuse and mental
23 illness conditions or diagnosis. Such clients are
24 sometimes referred to as mentally ill chemical abus-
25 ers (MICAs).

1 “(5) FETAL ALCOHOL SPECTRUM DIS-
2 ORDERS.—

3 “(A) IN GENERAL.—The term ‘fetal alco-
4 hol spectrum disorders’ includes a range of ef-
5 fects that can occur in an individual whose
6 mother drank alcohol during pregnancy, includ-
7 ing physical, mental, behavioral, and/or learning
8 disabilities with possible lifelong implications.

9 “(B) INCLUSIONS.—The term ‘fetal alcohol
10 spectrum disorders’ may include—

11 “(i) fetal alcohol syndrome (FAS);

12 “(ii) partial fetal alcohol syndrome
13 (partial FAS);

14 “(iii) alcohol-related birth defects
15 (ARBD); and

16 “(iv) alcohol-related
17 neurodevelopmental disorders (ARND).

18 “(6) FAS OR FETAL ALCOHOL SYNDROME.—

19 The term ‘FAS’ or ‘fetal alcohol syndrome’ means a
20 syndrome in which, with a history of maternal alco-
21 hol consumption during pregnancy, the following cri-
22 teria are met:

23 “(A) Central nervous system involvement,
24 such as mental retardation, developmental

1 delay, intellectual deficit, microencephaly, or
2 neurological abnormalities.

3 “(B) Craniofacial abnormalities with at
4 least 2 of the following:

5 “(i) Microphthalmia.

6 “(ii) Short palpebral fissures.

7 “(iii) Poorly developed philtrum.

8 “(iv) Thin upper lip.

9 “(v) Flat nasal bridge.

10 “(vi) Short upturned nose.

11 “(C) Prenatal or postnatal growth delay.

12 “(7) REHABILITATION.—The term ‘rehabilita-
13 tion’ means medical and health care services that—

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

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

20 “(C) have as their purpose any of the fol-
21 lowing:

22 “(i) The maximum attainment of
23 physical, mental, and developmental func-
24 tioning.

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

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

5 “(8) SUBSTANCE ABUSE.—The term ‘substance
6 abuse’ includes inhalant abuse.

7 **“SEC. 702. BEHAVIORAL HEALTH PREVENTION AND TREAT-**
8 **MENT SERVICES.**

9 “(a) PURPOSES.—The purposes of this section are as
10 follows:

11 “(1) To authorize and direct the Secretary, act-
12 ing through the Service, Indian tribes, and tribal or-
13 ganizations, to develop a comprehensive behavioral
14 health prevention and treatment program which em-
15 phasizes collaboration among alcohol and substance
16 abuse, social services, and mental health programs.

17 “(2) To provide information, direction, and
18 guidance relating to mental illness and dysfunction
19 and self-destructive behavior, including child abuse
20 and family violence, to those Federal, tribal, State,
21 and local agencies responsible for programs in In-
22 dian communities in areas of health care, education,
23 social services, child and family welfare, alcohol and
24 substance abuse, law enforcement, and judicial serv-
25 ices.

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

4 “(4) To provide authority and opportunities for
5 Indian tribes and tribal organizations to develop, im-
6 plement, and coordinate with community-based pro-
7 grams which include identification, prevention, edu-
8 cation, referral, and treatment services, including
9 through multidisciplinary resource teams.

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

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

17 “(b) PLANS.—

18 “(1) DEVELOPMENT.—The Secretary, acting
19 through the Service, Indian tribes, and tribal organi-
20 zations, shall encourage Indian tribes and tribal or-
21 ganizations to develop tribal plans, and urban Indian
22 organizations to develop local plans, and for all such
23 groups to participate in developing areawide plans
24 for Indian Behavioral Health Services. The plans

1 shall include, to the extent feasible, the following
2 components:

3 “(A) An assessment of the scope of alcohol
4 or other substance abuse, mental illness, and
5 dysfunctional and self-destructive behavior, in-
6 cluding suicide, child abuse, and family vio-
7 lence, among Indians, including—

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

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

14 “(B) An assessment of the existing and
15 additional resources necessary for the preven-
16 tion and treatment of such illness and behavior,
17 including an assessment of the progress toward
18 achieving the availability of the full continuum
19 of care described in subsection (c).

20 “(C) An estimate of the additional funding
21 needed by the Service, Indian tribes, tribal or-
22 ganizations, and urban Indian organizations to
23 meet their responsibilities under the plans.

24 “(2) NATIONAL CLEARINGHOUSE.—The Sec-
25 retary, acting through the Service, shall coordinate

1 with existing national clearinghouses and informa-
2 tion centers to include at the clearinghouses and
3 centers plans and reports on the outcomes of such
4 plans developed by Indian tribes, tribal organiza-
5 tions, urban Indian organizations, and Service areas
6 relating to behavioral health. The Secretary shall en-
7 sure access to these plans and outcomes by any In-
8 dian tribe, tribal organization, urban Indian organi-
9 zation, or the Service.

10 “(3) TECHNICAL ASSISTANCE.—The Secretary
11 shall provide technical assistance to Indian tribes,
12 tribal organizations, and urban Indian organizations
13 in preparation of plans under this section and in de-
14 veloping standards of care that may be used and
15 adopted locally.

16 “(c) PROGRAMS.—The Secretary, acting through the
17 Service, shall provide, to the extent feasible and if funding
18 is available, programs including the following:

19 “(1) COMPREHENSIVE CARE.—A comprehensive
20 continuum of behavioral health care which pro-
21 vides—

22 “(A) community-based prevention, inter-
23 vention, outpatient, and behavioral health
24 aftercare;

25 “(B) detoxification (social and medical);

1 “(C) acute hospitalization;

2 “(D) intensive outpatient/day treatment;

3 “(E) residential treatment;

4 “(F) transitional living for those needing a
5 temporary, stable living environment that is
6 supportive of treatment and recovery goals;

7 “(G) emergency shelter;

8 “(H) intensive case management;

9 “(I) diagnostic services; and

10 “(J) promotion of healthy approaches to
11 risk and safety issues, including injury preven-
12 tion.

13 “(2) CHILD CARE.—Behavioral health services
14 for Indians from birth through age 17, including—

15 “(A) preschool and school age fetal alcohol
16 spectrum disorder services, including assess-
17 ment and behavioral intervention;

18 “(B) mental health and substance abuse
19 services (emotional, organic, alcohol, drug, in-
20 halant, and tobacco);

21 “(C) identification and treatment of co-oc-
22 ccurring disorders and comorbidity;

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

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

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

5 “(G) identification and treatment of ne-
6 glect and physical, mental, and sexual abuse.

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

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

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

14 “(C) identification and treatment of co-oc-
15 curring disorders (dual diagnosis) and comor-
16 bidity;

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

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

22 “(F) sex specific treatment for sexual as-
23 sault and domestic violence.

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

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

3 “(B) treatment for sexual assault and do-
4 mestic violence; and

5 “(C) promotion of healthy approaches re-
6 lating to parenting, domestic violence, and other
7 abuse issues.

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

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

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

15 “(C) identification and treatment of co-oc-
16 curring disorders (dual diagnosis) and comor-
17 bidity;

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

20 “(E) sex specific treatment for sexual as-
21 sault, domestic violence, neglect, physical and
22 mental abuse and exploitation; and

23 “(F) identification and treatment of de-
24 mentias regardless of cause.

25 “(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

1 “(1) ESTABLISHMENT.—The governing body of
2 any Indian tribe, tribal organization, or urban In-
3 dian organization may adopt a resolution for the es-
4 tablishment of a community behavioral health plan
5 providing for the identification and coordination of
6 available resources and programs to identify, pre-
7 vent, or treat substance abuse, mental illness, or
8 dysfunctional and self-destructive behavior, including
9 child abuse and family violence, among its members
10 or its service population. This plan should include
11 behavioral health services, social services, intensive
12 outpatient services, and continuing aftercare.

13 “(2) TECHNICAL ASSISTANCE.—At the request
14 of an Indian tribe, tribal organization, or urban In-
15 dian organization, the Bureau of Indian Affairs and
16 the Service shall cooperate with and provide tech-
17 nical assistance to the Indian tribe, tribal organiza-
18 tion, or urban Indian organization in the develop-
19 ment and implementation of such plan.

20 “(3) FUNDING.—The Secretary, acting through
21 the Service, Indian tribes, and tribal organizations,
22 may make funding available to Indian tribes and
23 tribal organizations which adopt a resolution pursu-
24 ant to paragraph (1) to obtain technical assistance
25 for the development of a community behavioral

1 health plan and to provide administrative support in
2 the implementation of such plan.

3 “(e) COORDINATION FOR AVAILABILITY OF SERV-
4 ICES.—The Secretary, acting through the Service, shall
5 coordinate behavioral health planning, to the extent fea-
6 sible, with other Federal agencies and with State agencies,
7 to encourage comprehensive behavioral health services for
8 Indians regardless of their place of residence.

9 “(f) MENTAL HEALTH CARE NEED ASSESSMENT.—
10 Not later than 1 year after the date of enactment of the
11 Indian Health Care Improvement Reauthorization and
12 Extension Act of 2009, the Secretary, acting through the
13 Service, shall make an assessment of the need for inpa-
14 tient mental health care among Indians and the avail-
15 ability and cost of inpatient mental health facilities which
16 can meet such need. In making such assessment, the Sec-
17 retary shall consider the possible conversion of existing,
18 underused Service hospital beds into psychiatric units to
19 meet such need.

20 **“SEC. 703. MEMORANDA OF AGREEMENT WITH THE DE-**
21 **PARTMENT OF INTERIOR.**

22 “(a) CONTENTS.—Not later than 1 year after the
23 date of enactment of the Indian Health Care Improvement
24 Reauthorization and Extension Act of 2009, the Sec-
25 retary, acting through the Service, and the Secretary of

1 the Interior shall develop and enter into a memoranda of
2 agreement, or review and update any existing memoranda
3 of agreement, as required by section 4205 of the Indian
4 Alcohol and Substance Abuse Prevention and Treatment
5 Act of 1986 (25 U.S.C. 2411) under which the Secretaries
6 address the following:

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

10 “(2) The existing Federal, tribal, State, local,
11 and private services, resources, and programs avail-
12 able to provide behavioral health services for Indi-
13 ans.

14 “(3) The unmet need for additional services, re-
15 sources, and programs necessary to meet the needs
16 identified pursuant to paragraph (1).

17 “(4)(A) The right of Indians, as citizens of the
18 United States and of the States in which they re-
19 side, to have access to behavioral health services to
20 which all citizens have access.

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

23 “(C) The actions necessary to protect the exer-
24 cise of such right.

1 “(5) The responsibilities of the Bureau of In-
2 dian Affairs and the Service, including mental illness
3 identification, prevention, education, referral, and
4 treatment services (including services through multi-
5 disciplinary resource teams), at the central, area,
6 and agency and Service unit, Service area, and head-
7 quarters levels to address the problems identified in
8 paragraph (1).

9 “(6) A strategy for the comprehensive coordina-
10 tion of the behavioral health services provided by the
11 Bureau of Indian Affairs and the Service to meet
12 the problems identified pursuant to paragraph (1),
13 including—

14 “(A) the coordination of alcohol and sub-
15 stance abuse programs of the Service, the Bu-
16 reau of Indian Affairs, and Indian tribes and
17 tribal organizations (developed under the Indian
18 Alcohol and Substance Abuse Prevention and
19 Treatment Act of 1986 (25 U.S.C. 2401 et
20 seq.)) with behavioral health initiatives pursu-
21 ant to this Act, particularly with respect to the
22 referral and treatment of dually diagnosed indi-
23 viduals requiring behavioral health and sub-
24 stance abuse treatment; and

1 “(B) ensuring that the Bureau of Indian
2 Affairs and Service programs and services (in-
3 cluding multidisciplinary resource teams) ad-
4 dressing child abuse and family violence are co-
5 ordinated with such non-Federal programs and
6 services.

7 “(7) Directing appropriate officials of the Bu-
8 reau of Indian Affairs and the Service, particularly
9 at the agency and Service unit levels, to cooperate
10 fully with tribal requests made pursuant to commu-
11 nity behavioral health plans adopted under section
12 702(c) and section 4206 of the Indian Alcohol and
13 Substance Abuse Prevention and Treatment Act of
14 1986 (25 U.S.C. 2412).

15 “(8) Providing for an annual review of such
16 agreement by the Secretaries which shall be provided
17 to Congress and Indian tribes and tribal organiza-
18 tions.

19 “(b) SPECIFIC PROVISIONS REQUIRED.—The memo-
20 randa of agreement updated or entered into pursuant to
21 subsection (a) shall include specific provisions pursuant to
22 which the Service shall assume responsibility for—

23 “(1) the determination of the scope of the prob-
24 lem of alcohol and substance abuse among Indians,
25 including the number of Indians within the jurisdic-

1 and aftercare, which may include, if feasible and ap-
2 propriate, systems of care, and shall include—

3 “(A) prevention, through educational inter-
4 vention, in Indian communities;

5 “(B) acute detoxification, psychiatric hos-
6 pitalization, residential, and intensive outpatient
7 treatment;

8 “(C) community-based rehabilitation and
9 aftercare;

10 “(D) community education and involve-
11 ment, including extensive training of health
12 care, educational, and community-based per-
13 sonnel;

14 “(E) specialized residential treatment pro-
15 grams for high-risk populations, including preg-
16 nant and postpartum women and their children;
17 and

18 “(F) diagnostic services.

19 “(2) TARGET POPULATIONS.—The target popu-
20 lation of such programs shall be members of Indian
21 tribes. Efforts to train and educate key members of
22 the Indian community shall also target employees of
23 health, education, judicial, law enforcement, legal,
24 and social service programs.

25 “(b) CONTRACT HEALTH SERVICES.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Service, may enter into contracts with
3 public or private providers of behavioral health treat-
4 ment services for the purpose of carrying out the
5 program required under subsection (a).

6 “(2) PROVISION OF ASSISTANCE.—In carrying
7 out this subsection, the Secretary shall provide as-
8 sistance to Indian tribes and tribal organizations to
9 develop criteria for the certification of behavioral
10 health service providers and accreditation of service
11 facilities which meet minimum standards for such
12 services and facilities.

13 **“SEC. 705. MENTAL HEALTH TECHNICIAN PROGRAM.**

14 “(a) IN GENERAL.—Pursuant to the Act of Novem-
15 ber 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Sny-
16 der Act’), the Secretary shall establish and maintain a
17 mental health technician program within the Service
18 which—

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

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

1 “(b) PARAPROFESSIONAL TRAINING.—In carrying
2 out subsection (a), the Secretary, acting through the Serv-
3 ice, shall provide high-standard paraprofessional training
4 in mental health care necessary to provide quality care to
5 the Indian communities to be served. Such training shall
6 be based upon a curriculum developed or approved by the
7 Secretary which combines education in the theory of men-
8 tal health care with supervised practical experience in the
9 provision of such care.

10 “(c) SUPERVISION AND EVALUATION OF TECHNI-
11 CIANS.—The Secretary, acting through the Service, shall
12 supervise and evaluate the mental health technicians in
13 the training program.

14 “(d) TRADITIONAL HEALTH CARE PRACTICES.—The
15 Secretary, acting through the Service, shall ensure that
16 the program established pursuant to this section involves
17 the use and promotion of the traditional health care prac-
18 tices of the Indian tribes to be served.

19 **“SEC. 706. LICENSING REQUIREMENT FOR MENTAL**
20 **HEALTH CARE WORKERS.**

21 “(a) IN GENERAL.—Subject to section 221, and ex-
22 cept as provided in subsection (b), any individual employed
23 as a psychologist, social worker, or marriage and family
24 therapist for the purpose of providing mental health care
25 services to Indians in a clinical setting under this Act is

1 required to be licensed as a psychologist, social worker,
2 or marriage and family therapist, respectively.

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

7 “(1) works under the direct supervision of a li-
8 censed psychologist, social worker, or marriage and
9 family therapist, respectively;

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

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

17 **“SEC. 707. INDIAN WOMEN TREATMENT PROGRAMS.**

18 “(a) GRANTS.—The Secretary, consistent with sec-
19 tion 702, may make grants to Indian tribes, tribal organi-
20 zations, and urban Indian organizations to develop and
21 implement a comprehensive behavioral health program of
22 prevention, intervention, treatment, and relapse preven-
23 tion services that specifically addresses the cultural, his-
24 torical, social, and child care needs of Indian women, re-
25 gardless of age.

1 “(b) USE OF GRANT FUNDS.—A grant made pursu-
2 ant to this section may be used—

3 “(1) to develop and provide community train-
4 ing, education, and prevention programs for Indian
5 women relating to behavioral health issues, including
6 fetal alcohol spectrum disorders;

7 “(2) to identify and provide psychological serv-
8 ices, counseling, advocacy, support, and relapse pre-
9 vention to Indian women and their families; and

10 “(3) to develop prevention and intervention
11 models for Indian women which incorporate tradi-
12 tional health care practices, cultural values, and
13 community and family involvement.

14 “(c) CRITERIA.—The Secretary, in consultation with
15 Indian tribes and tribal organizations, shall establish cri-
16 teria for the review and approval of applications and pro-
17 posals for funding under this section.

18 “(d) ALLOCATION OF FUNDS FOR URBAN INDIAN
19 ORGANIZATIONS.—20 percent of the funds appropriated
20 pursuant to this section shall be used to make grants to
21 urban Indian organizations.

22 **“SEC. 708. INDIAN YOUTH PROGRAM.**

23 “(a) DETOXIFICATION AND REHABILITATION.—The
24 Secretary, acting through the Service, consistent with sec-
25 tion 702, shall develop and implement a program for acute

1 detoxification and treatment for Indian youths, including
2 behavioral health services. The program shall include re-
3 gional treatment centers designed to include detoxification
4 and rehabilitation for both sexes on a referral basis and
5 programs developed and implemented by Indian tribes or
6 tribal organizations at the local level under the Indian
7 Self-Determination and Education Assistance Act (25
8 U.S.C. 450 et seq.). Regional centers shall be integrated
9 with the intake and rehabilitation programs based in the
10 referring Indian community.

11 “(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT
12 CENTERS OR FACILITIES.—

13 “(1) ESTABLISHMENT.—

14 “(A) IN GENERAL.—The Secretary, acting
15 through the Service, shall construct, renovate,
16 or, as necessary, purchase, and appropriately
17 staff and operate, at least 1 youth regional
18 treatment center or treatment network in each
19 area under the jurisdiction of an area office.

20 “(B) AREA OFFICE IN CALIFORNIA.—For
21 the purposes of this subsection, the area office
22 in California shall be considered to be 2 area
23 offices, 1 office whose jurisdiction shall be con-
24 sidered to encompass the northern area of the
25 State of California, and 1 office whose jurisdic-

1 “(ii) the Southeast Alaska Regional
2 Health Corporation to staff and operate a
3 residential youth treatment facility without
4 regard to the proviso set forth in section
5 4(l) of the Indian Self-Determination and
6 Education Assistance Act (25 U.S.C.
7 450b(l)).

8 “(B) PROVISION OF SERVICES TO ELIGI-
9 BLE YOUTHS.—Until additional residential
10 youth treatment facilities are established in
11 Alaska pursuant to this section, the facilities
12 specified in subparagraph (A) shall make every
13 effort to provide services to all eligible Indian
14 youths residing in Alaska.

15 “(c) INTERMEDIATE ADOLESCENT BEHAVIORAL
16 HEALTH SERVICES.—

17 “(1) IN GENERAL.—The Secretary, acting
18 through the Service, may provide intermediate be-
19 havioral health services, which may, if feasible and
20 appropriate, incorporate systems of care, to Indian
21 children and adolescents, including—

22 “(A) pretreatment assistance;

23 “(B) inpatient, outpatient, and aftercare
24 services;

25 “(C) emergency care;

1 “(D) suicide prevention and crisis interven-
2 tion; and

3 “(E) prevention and treatment of mental
4 illness and dysfunctional and self-destructive
5 behavior, including child abuse and family vio-
6 lence.

7 “(2) USE OF FUNDS.—Funds provided under
8 this subsection may be used—

9 “(A) to construct or renovate an existing
10 health facility to provide intermediate behav-
11 ioral health services;

12 “(B) to hire behavioral health profes-
13 sionals;

14 “(C) to staff, operate, and maintain an in-
15 termediate mental health facility, group home,
16 sober housing, transitional housing or similar
17 facilities, or youth shelter where intermediate
18 behavioral health services are being provided;

19 “(D) to make renovations and hire appro-
20 priate staff to convert existing hospital beds
21 into adolescent psychiatric units; and

22 “(E) for intensive home- and community-
23 based services.

24 “(3) CRITERIA.—The Secretary, acting through
25 the Service, shall, in consultation with Indian tribes

1 and tribal organizations, establish criteria for the re-
2 view and approval of applications or proposals for
3 funding made available pursuant to this subsection.

4 “(d) **FEDERALLY OWNED STRUCTURES.**—

5 “(1) **IN GENERAL.**—The Secretary, in consulta-
6 tion with Indian tribes and tribal organizations,
7 shall—

8 “(A) identify and use, where appropriate,
9 federally owned structures suitable for local res-
10 idential or regional behavioral health treatment
11 for Indian youths; and

12 “(B) establish guidelines for determining
13 the suitability of any such federally owned
14 structure to be used for local residential or re-
15 gional behavioral health treatment for Indian
16 youths.

17 “(2) **TERMS AND CONDITIONS FOR USE OF**
18 **STRUCTURE.**—Any structure described in paragraph
19 (1) may be used under such terms and conditions as
20 may be agreed upon by the Secretary and the agency
21 having responsibility for the structure and any In-
22 dian tribe or tribal organization operating the pro-
23 gram.

24 “(e) **REHABILITATION AND AFTERCARE SERVICES.**—

1 “(1) IN GENERAL.—The Secretary, Indian
2 tribes, or tribal organizations, in cooperation with
3 the Secretary of the Interior, shall develop and im-
4 plement within each Service unit, community-based
5 rehabilitation and follow-up services for Indian
6 youths who are having significant behavioral health
7 problems, and require long-term treatment, commu-
8 nity reintegration, and monitoring to support the In-
9 dian youths after their return to their home commu-
10 nity.

11 “(2) ADMINISTRATION.—Services under para-
12 graph (1) shall be provided by trained staff within
13 the community who can assist the Indian youths in
14 their continuing development of self-image, positive
15 problem-solving skills, and nonalcohol or substance
16 abusing behaviors. Such staff may include alcohol
17 and substance abuse counselors, mental health pro-
18 fessionals, and other health professionals and para-
19 professionals, including community health represent-
20 atives.

21 “(f) INCLUSION OF FAMILY IN YOUTH TREATMENT
22 PROGRAM.—In providing the treatment and other services
23 to Indian youths authorized by this section, the Secretary,
24 acting through the Service, shall provide for the inclusion
25 of family members of such youths in the treatment pro-

1 grams or other services as may be appropriate. Not less
2 than 10 percent of the funds appropriated for the pur-
3 poses of carrying out subsection (e) shall be used for out-
4 patient care of adult family members related to the treat-
5 ment of an Indian youth under that subsection.

6 “(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
7 acting through the Service, shall provide, consistent with
8 section 702, programs and services to prevent and treat
9 the abuse of multiple forms of substances, including alco-
10 hol, drugs, inhalants, and tobacco, among Indian youths
11 residing in Indian communities, on or near reservations,
12 and in urban areas and provide appropriate mental health
13 services to address the incidence of mental illness among
14 such youths.

15 “(h) INDIAN YOUTH MENTAL HEALTH.—The Sec-
16 retary, acting through the Service, shall collect data for
17 the report under section 801 with respect to—

18 “(1) the number of Indian youth who are being
19 provided mental health services through the Service
20 and tribal health programs;

21 “(2) a description of, and costs associated with,
22 the mental health services provided for Indian youth
23 through the Service and tribal health programs;

1 “(3) the number of youth referred to the Serv-
2 ice or tribal health programs for mental health serv-
3 ices;

4 “(4) the number of Indian youth provided resi-
5 dential treatment for mental health and behavioral
6 problems through the Service and tribal health pro-
7 grams, reported separately for on- and off-reserva-
8 tion facilities; and

9 “(5) the costs of the services described in para-
10 graph (4).

11 **“SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL**
12 **HEALTH FACILITIES DESIGN, CONSTRUC-**
13 **TION, AND STAFFING.**

14 “Not later than 1 year after the date of enactment
15 of the Indian Health Care Improvement Reauthorization
16 and Extension Act of 2009, the Secretary, acting through
17 the Service, may provide, in each area of the Service, not
18 less than 1 inpatient mental health care facility, or the
19 equivalent, for Indians with behavioral health problems.
20 For the purposes of this subsection, California shall be
21 considered to be 2 area offices, 1 office whose location
22 shall be considered to encompass the northern area of the
23 State of California and 1 office whose jurisdiction shall
24 be considered to encompass the remainder of the State
25 of California. The Secretary shall consider the possible

1 conversion of existing, underused Service hospital beds
2 into psychiatric units to meet such need.

3 **“SEC. 710. TRAINING AND COMMUNITY EDUCATION.**

4 “(a) PROGRAM.—The Secretary, in cooperation with
5 the Secretary of the Interior, shall develop and implement
6 or assist Indian tribes and tribal organizations to develop
7 and implement, within each Service unit or tribal program,
8 a program of community education and involvement which
9 shall be designed to provide concise and timely information
10 to the community leadership of each tribal community.
11 Such program shall include education about behavioral
12 health issues to political leaders, tribal judges, law en-
13 forcement personnel, members of tribal health and edu-
14 cation boards, health care providers including traditional
15 practitioners, and other critical members of each tribal
16 community. Such program may also include community-
17 based training to develop local capacity and tribal commu-
18 nity provider training for prevention, intervention, treat-
19 ment, and aftercare.

20 “(b) INSTRUCTION.—The Secretary, acting through
21 the Service, shall provide instruction in the area of behav-
22 ioral health issues, including instruction in crisis interven-
23 tion and family relations in the context of alcohol and sub-
24 stance abuse, child sexual abuse, youth alcohol and sub-
25 stance abuse, and the causes and effects of fetal alcohol

1 spectrum disorders to appropriate employees of the Bu-
2 reau of Indian Affairs and the Service, and to personnel
3 in schools or programs operated under any contract with
4 the Bureau of Indian Affairs or the Service, including su-
5 pervisors of emergency shelters and halfway houses de-
6 scribed in section 4213 of the Indian Alcohol and Sub-
7 stance Abuse Prevention and Treatment Act of 1986 (25
8 U.S.C. 2433).

9 “(c) TRAINING MODELS.—In carrying out the edu-
10 cation and training programs required by this section, the
11 Secretary, in consultation with Indian tribes, tribal organi-
12 zations, Indian behavioral health experts, and Indian alco-
13 hol and substance abuse prevention experts, shall develop
14 and provide community-based training models. Such mod-
15 els shall address—

16 “(1) the elevated risk of alcohol abuse and
17 other behavioral health problems faced by children of
18 alcoholics;

19 “(2) the cultural, spiritual, and
20 multigenerational aspects of behavioral health prob-
21 lem prevention and recovery; and

22 “(3) community-based and multidisciplinary
23 strategies for preventing and treating behavioral
24 health problems.

1 **“SEC. 711. BEHAVIORAL HEALTH PROGRAM.**

2 “(a) INNOVATIVE PROGRAMS.—The Secretary, acting
3 through the Service, consistent with section 702, may
4 plan, develop, implement, and carry out programs to de-
5 liver innovative community-based behavioral health serv-
6 ices to Indians.

7 “(b) AWARDS; CRITERIA.—The Secretary may award
8 a grant for a project under subsection (a) to an Indian
9 tribe or tribal organization and may consider the following
10 criteria:

11 “(1) The project will address significant unmet
12 behavioral health needs among Indians.

13 “(2) The project will serve a significant number
14 of Indians.

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

17 “(4) The Indian tribe or tribal organization has
18 the administrative and financial capability to admin-
19 ister the project.

20 “(5) The project may deliver services in a man-
21 ner consistent with traditional health care practices.

22 “(6) The project is coordinated with, and avoids
23 duplication of, existing services.

24 “(c) EQUITABLE TREATMENT.—For purposes of this
25 subsection, the Secretary shall, in evaluating project appli-
26 cations or proposals, use the same criteria that the Sec-

1 retary uses in evaluating any other application or proposal
2 for such funding.

3 **“SEC. 712. FETAL ALCOHOL SPECTRUM DISORDERS PRO-**
4 **GRAMS.**

5 “(a) PROGRAMS.—

6 “(1) ESTABLISHMENT.—The Secretary, con-
7 sistent with section 702, acting through the Service,
8 Indian tribes, and Tribal Organizations, is author-
9 ized to establish and operate fetal alcohol spectrum
10 disorders programs as provided in this section for
11 the purposes of meeting the health status objectives
12 specified in section 3.

13 “(2) USE OF FUNDS.—

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

17 “(i) To develop and provide for Indi-
18 ans community and in-school training, edu-
19 cation, and prevention programs relating
20 to fetal alcohol spectrum disorders.

21 “(ii) To identify and provide behav-
22 ioral health treatment to high-risk Indian
23 women and high-risk women pregnant with
24 an Indian’s child.

1 “(iii) To identify and provide appro-
2 priate psychological services, educational
3 and vocational support, counseling, advoca-
4 cacy, and information to fetal alcohol spec-
5 trum disorders-affected Indians and their
6 families or caretakers.

7 “(iv) To develop and implement coun-
8 seling and support programs in schools for
9 fetal alcohol spectrum disorders-affected
10 Indian children.

11 “(v) To develop prevention and inter-
12 vention models which incorporate practi-
13 tioners of traditional health care practices,
14 cultural values, and community involve-
15 ment.

16 “(vi) To develop, print, and dissemi-
17 nate education and prevention materials on
18 fetal alcohol spectrum disorders.

19 “(vii) To develop and implement, in
20 consultation with Indian tribes and tribal
21 organizations, and in conference with
22 urban Indian organizations, culturally sen-
23 sitive assessment and diagnostic tools in-
24 cluding dysmorphology clinics and multi-
25 disciplinary fetal alcohol spectrum dis-

1 orders clinics for use in Indian commu-
2 nities and urban centers.

3 “(viii) To develop and provide training
4 on fetal alcohol spectrum disorders to pro-
5 fessionals providing services to Indians, in-
6 cluding medical and allied health practi-
7 tioners, social service providers, educators,
8 and law enforcement, court officials and
9 corrections personnel in the juvenile and
10 criminal justice systems.

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

15 “(i) Early childhood intervention
16 projects from birth on to mitigate the ef-
17 fects of fetal alcohol spectrum disorders
18 among Indians.

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

22 “(iii) Community-based housing for
23 adult Indians with fetal alcohol spectrum
24 disorders.

1 “(3) CRITERIA FOR APPLICATIONS.—The Sec-
2 retary shall establish criteria for the review and ap-
3 proval of applications for funding under this section.

4 “(b) SERVICES.—The Secretary, acting through the
5 Service, Indian tribes, and tribal organizations, shall—

6 “(1) develop and provide services for the pre-
7 vention, intervention, treatment, and aftercare for
8 those affected by fetal alcohol spectrum disorders in
9 Indian communities; and

10 “(2) provide supportive services, including serv-
11 ices to meet the special educational, vocational,
12 school-to-work transition, and independent living
13 needs of adolescent and adult Indians with fetal al-
14 cohol spectrum disorders.

15 “(c) APPLIED RESEARCH PROJECTS.—The Sec-
16 retary, acting through the Substance Abuse and Mental
17 Health Services Administration, shall make grants to In-
18 dian tribes, tribal organizations, and urban Indian organi-
19 zations for applied research projects which propose to ele-
20 vate the understanding of methods to prevent, intervene,
21 treat, or provide rehabilitation and behavioral health
22 aftercare for Indians and urban Indians affected by fetal
23 alcohol spectrum disorders.

24 “(d) FUNDING FOR URBAN INDIAN ORGANIZA-
25 TIONS.—Ten percent of the funds appropriated pursuant

1 to this section shall be used to make grants to urban In-
2 dian organizations funded under title V.

3 **“SEC. 713. CHILD SEXUAL ABUSE PREVENTION AND TREAT-**
4 **MENT PROGRAMS.**

5 “(a) ESTABLISHMENT.—The Secretary, acting
6 through the Service, shall establish, consistent with section
7 702, in every Service area, programs involving treatment
8 for—

9 “(1) victims of sexual abuse who are Indian
10 children or children in an Indian household; and

11 “(2) other members of the household or family
12 of the victims described in paragraph (1).

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

15 “(1) To develop and provide community edu-
16 cation and prevention programs related to sexual
17 abuse of Indian children or children in an Indian
18 household.

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

24 “(3) To develop prevention and intervention
25 models which incorporate traditional health care

1 practices, cultural values, and community involve-
2 ment.

3 “(4) To develop and implement culturally sen-
4 sitive assessment and diagnostic tools for use in In-
5 dian communities and urban centers.

6 “(c) COORDINATION.—The programs established
7 under subsection (a) shall be carried out in coordination
8 with programs and services authorized under the Indian
9 Child Protection and Family Violence Prevention Act (25
10 U.S.C. 3201 et seq.).

11 **“SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION**
12 **AND TREATMENT.**

13 “(a) IN GENERAL.—The Secretary, in accordance
14 with section 702, is authorized to establish in each Service
15 area programs involving the prevention and treatment
16 of—

17 “(1) Indian victims of domestic violence or sex-
18 ual abuse; and

19 “(2) other members of the household or family
20 of the victims described in paragraph (1).

21 “(b) USE OF FUNDS.—Funds made available to carry
22 out this section shall be used—

23 “(1) to develop and implement prevention pro-
24 grams and community education programs relating
25 to domestic violence and sexual abuse;

1 “(2) to provide behavioral health services, in-
2 cluding victim support services, and medical treat-
3 ment (including examinations performed by sexual
4 assault nurse examiners) to Indian victims of domes-
5 tic violence or sexual abuse;

6 “(3) to purchase rape kits; and

7 “(4) to develop prevention and intervention
8 models, which may incorporate traditional health
9 care practices.

10 “(c) TRAINING AND CERTIFICATION.—

11 “(1) IN GENERAL.—Not later than 1 year after
12 the date of enactment of the Indian Health Care Im-
13 provement Reauthorization and Extension Act of
14 2009, the Secretary shall establish appropriate pro-
15 tocols, policies, procedures, standards of practice,
16 and, if not available elsewhere, training curricula
17 and training and certification requirements for serv-
18 ices for victims of domestic violence and sexual
19 abuse.

20 “(2) REPORT.—Not later than 18 months after
21 the date of enactment of the Indian Health Care Im-
22 provement Reauthorization and Extension Act of
23 2009, the Secretary shall submit to the Committee
24 on Indian Affairs of the Senate and the Committee
25 on Natural Resources of the House of Representa-

1 tives a report that describes the means and extent
2 to which the Secretary has carried out paragraph
3 (1).

4 “(d) COORDINATION.—

5 “(1) IN GENERAL.—The Secretary, in coordina-
6 tion with the Attorney General, Federal and tribal
7 law enforcement agencies, Indian health programs,
8 and domestic violence or sexual assault victim orga-
9 nizations, shall develop appropriate victim services
10 and victim advocate training programs—

11 “(A) to improve domestic violence or sex-
12 ual abuse responses;

13 “(B) to improve forensic examinations and
14 collection;

15 “(C) to identify problems or obstacles in
16 the prosecution of domestic violence or sexual
17 abuse; and

18 “(D) to meet other needs or carry out
19 other activities required to prevent, treat, and
20 improve prosecutions of domestic violence and
21 sexual abuse.

22 “(2) REPORT.—Not later than 2 years after the
23 date of enactment of the Indian Health Care Im-
24 provement Reauthorization and Extension Act of
25 2009, the Secretary shall submit to the Committee

1 on Indian Affairs of the Senate and the Committee
2 on Natural Resources of the House of Representa-
3 tives a report that describes, with respect to the
4 matters described in paragraph (1), the improve-
5 ments made and needed, problems or obstacles iden-
6 tified, and costs necessary to address the problems
7 or obstacles, and any other recommendations that
8 the Secretary determines to be appropriate.

9 **“SEC. 715. BEHAVIORAL HEALTH RESEARCH.**

10 “(a) IN GENERAL.—The Secretary, in consultation
11 with appropriate Federal agencies, shall make grants to,
12 or enter into contracts with, Indian tribes, tribal organiza-
13 tions, and urban Indian organizations or enter into con-
14 tracts with, or make grants to appropriate institutions for,
15 the conduct of research on the incidence and prevalence
16 of behavioral health problems among Indians served by the
17 Service, Indian tribes, or tribal organizations and among
18 Indians in urban areas. Research priorities under this sec-
19 tion shall include—

20 “(1) the multifactorial causes of Indian youth
21 suicide, including—

22 “(A) protective and risk factors and sci-
23 entific data that identifies those factors; and

1 “(ii) the highest rate of any population
2 group in the United States;

3 “(2) many risk behaviors and contributing fac-
4 tors for suicide are more prevalent in Indian country
5 than in other areas, including—

6 “(A) history of previous suicide attempts;

7 “(B) family history of suicide;

8 “(C) history of depression or other mental
9 illness;

10 “(D) alcohol or drug abuse;

11 “(E) health disparities;

12 “(F) stressful life events and losses;

13 “(G) easy access to lethal methods;

14 “(H) exposure to the suicidal behavior of
15 others;

16 “(I) isolation; and

17 “(J) incarceration;

18 “(3) according to national data for 2005, sui-
19 cide was the second-leading cause of death for Indi-
20 ans and Alaska Natives of both sexes aged 10
21 through 34;

22 “(4)(A) the suicide rates of Indian and Alaska
23 Native males aged 15 through 24 are—

1 “(i) as compared to suicide rates of males
2 of any other racial group, up to 4 times greater;
3 and

4 “(ii) as compared to suicide rates of fe-
5 males of any other racial group, up to 11 times
6 greater; and

7 “(B) data demonstrates that, over their life-
8 times, females attempt suicide 2 to 3 times more
9 often than males;

10 “(5)(A) Indian tribes, especially Indian tribes
11 located in the Great Plains, have experienced epi-
12 demic levels of suicide, up to 10 times the national
13 average; and

14 “(B) suicide clustering in Indian country affects
15 entire tribal communities;

16 “(6) death rates for Indians and Alaska Natives
17 are statistically underestimated because many areas
18 of Indian country lack the proper resources to iden-
19 tify and monitor the presence of disease;

20 “(7)(A) the Indian Health Service experiences
21 health professional shortages, with physician vacancy
22 rates of approximately 17 percent, and nursing va-
23 cancy rates of approximately 18 percent, in 2007;

1 “(B) 90 percent of all teens who die by suicide
2 suffer from a diagnosable mental illness at time of
3 death;

4 “(C) more than $\frac{1}{2}$ of teens who die by suicide
5 have never been seen by a mental health provider;
6 and

7 “(D) $\frac{1}{3}$ of health needs in Indian country re-
8 late to mental health;

9 “(8) often, the lack of resources of Indian
10 tribes and the remote nature of Indian reservations
11 make it difficult to meet the requirements necessary
12 to access Federal assistance, including grants;

13 “(9) the Substance Abuse and Mental Health
14 Services Administration and the Service have estab-
15 lished specific initiatives to combat youth suicide in
16 Indian country and among Indians and Alaska Na-
17 tives throughout the United States, including the
18 National Suicide Prevention Initiative of the Service,
19 which has worked with Service, tribal, and urban In-
20 dian health programs since 2003;

21 “(10) the National Strategy for Suicide Preven-
22 tion was established in 2001 through a Department
23 of Health and Human Services collaboration
24 among—

1 “(A) the Substance Abuse and Mental
2 Health Services Administration;

3 “(B) the Service;

4 “(C) the Centers for Disease Control and
5 Prevention;

6 “(D) the National Institutes of Health;
7 and

8 “(E) the Health Resources and Services
9 Administration; and

10 “(11) the Service and other agencies of the De-
11 partment of Health and Human Services use infor-
12 mation technology and other programs to address
13 the suicide prevention and mental health needs of
14 Indians and Alaska Natives.

15 “(b) PURPOSES.—The purposes of this subtitle are—

16 “(1) to authorize the Secretary to carry out a
17 demonstration project to test the use of telemental
18 health services in suicide prevention, intervention,
19 and treatment of Indian youth, including through—

20 “(A) the use of psychotherapy, psychiatric
21 assessments, diagnostic interviews, therapies for
22 mental health conditions predisposing to sui-
23 cide, and alcohol and substance abuse treat-
24 ment;

1 “(B) the provision of clinical expertise to,
2 consultation services with, and medical advice
3 and training for frontline health care providers
4 working with Indian youth;

5 “(C) training and related support for com-
6 munity leaders, family members, and health
7 and education workers who work with Indian
8 youth;

9 “(D) the development of culturally relevant
10 educational materials on suicide; and

11 “(E) data collection and reporting;

12 “(2) to encourage Indian tribes, tribal organiza-
13 tions, and other mental health care providers serving
14 residents of Indian country to obtain the services of
15 predoctoral psychology and psychiatry interns; and

16 “(3) to enhance the provision of mental health
17 care services to Indian youth through existing grant
18 programs of the Substance Abuse and Mental
19 Health Services Administration.

20 **“SEC. 722. DEFINITIONS.**

21 “In this subtitle:

22 “(1) ADMINISTRATION.—The term ‘Administra-
23 tion’ means the Substance Abuse and Mental Health
24 Services Administration.

1 “(2) DEMONSTRATION PROJECT.—The term
2 ‘demonstration project’ means the Indian youth tele-
3 mental health demonstration project authorized
4 under section 723(a).

5 “(3) TELEMENTAL HEALTH.—The term ‘tele-
6 mental health’ means the use of electronic informa-
7 tion and telecommunications technologies to support
8 long-distance mental health care, patient and profes-
9 sional-related education, public health, and health
10 administration.

11 **“SEC. 723. INDIAN YOUTH TELEMENTAL HEALTH DEM-**
12 **ONSTRATION PROJECT.**

13 “(a) AUTHORIZATION.—

14 “(1) IN GENERAL.—The Secretary, acting
15 through the Service, is authorized to carry out a
16 demonstration project to award grants for the provi-
17 sion of telemental health services to Indian youth
18 who—

19 “(A) have expressed suicidal ideas;

20 “(B) have attempted suicide; or

21 “(C) have behavioral health conditions that
22 increase or could increase the risk of suicide.

23 “(2) ELIGIBILITY FOR GRANTS.—Grants under
24 paragraph (1) shall be awarded to Indian tribes and

1 tribal organizations that operate 1 or more facili-
2 ties—

3 “(A) located in an area with documented
4 disproportionately high rates of suicide;

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

7 “(C) offering school-based telemental
8 health services to Indian youth.

9 “(3) GRANT PERIOD.—The Secretary shall
10 award grants under this section for a period of up
11 to 4 years.

12 “(4) MAXIMUM NUMBER OF GRANTS.—Not
13 more than 5 grants shall be provided under para-
14 graph (1), with priority consideration given to In-
15 dian tribes and tribal organizations that—

16 “(A) serve a particular community or geo-
17 graphic area in which there is a demonstrated
18 need to address Indian youth suicide;

19 “(B) enter into collaborative partnerships
20 with Service or other tribal health programs or
21 facilities to provide services under this dem-
22 onstration project;

23 “(C) serve an isolated community or geo-
24 graphic area that has limited or no access to
25 behavioral health services; or

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

3 “(5) CONSULTATION WITH ADMINISTRATION.—

4 In developing and carrying out the demonstration
5 project under this subsection, the Secretary shall
6 consult with the Administration as the Federal agen-
7 cy focused on mental health issues, including suicide.

8 “(b) USE OF FUNDS.—

9 “(1) IN GENERAL.—An Indian tribe or tribal
10 organization shall use a grant received under sub-
11 section (a) for the following purposes:

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

14 “(i) psychotherapy;

15 “(ii) psychiatric assessments and di-
16 agnostic interviews, therapies for mental
17 health conditions predisposing to suicide,
18 and treatment; and

19 “(iii) alcohol and substance abuse
20 treatment.

21 “(B) To provide clinician-interactive med-
22 ical advice, guidance and training, assistance in
23 diagnosis and interpretation, crisis counseling
24 and intervention, and related assistance to
25 Service or tribal clinicians and health services

1 providers working with youth being served
2 under the demonstration project.

3 “(C) To assist, educate, and train commu-
4 nity leaders, health education professionals and
5 paraprofessionals, tribal outreach workers, and
6 family members who work with the youth re-
7 ceiving telemental health services under the
8 demonstration project, including with identifica-
9 tion of suicidal tendencies, crisis intervention
10 and suicide prevention, emergency skill develop-
11 ment, and building and expanding networks
12 among those individuals and with State and
13 local health services providers.

14 “(D) To develop and distribute culturally
15 appropriate community educational materials
16 regarding—

17 “(i) suicide prevention;

18 “(ii) suicide education;

19 “(iii) suicide screening;

20 “(iv) suicide intervention; and

21 “(v) ways to mobilize communities
22 with respect to the identification of risk
23 factors for suicide.

1 “(E) To conduct data collection and re-
2 porting relating to Indian youth suicide preven-
3 tion efforts.

4 “(2) TRADITIONAL HEALTH CARE PRAC-
5 TICES.—In carrying out the purposes described in
6 paragraph (1), an Indian tribe or tribal organization
7 may use and promote the traditional health care
8 practices of the Indian tribes of the youth to be
9 served.

10 “(c) APPLICATIONS.—

11 “(1) IN GENERAL.—Subject to paragraph (2),
12 to be eligible to receive a grant under subsection (a),
13 an Indian tribe or tribal organization shall prepare
14 and submit to the Secretary an application, at such
15 time, in such manner, and containing such informa-
16 tion as the Secretary may require, including—

17 “(A) a description of the project that the
18 Indian tribe or tribal organization will carry out
19 using the funds provided under the grant;

20 “(B) a description of the manner in which
21 the project funded under the grant would—

22 “(i) meet the telemental health care
23 needs of the Indian youth population to be
24 served by the project; or

1 “(ii) improve the access of the Indian
2 youth population to be served to suicide
3 prevention and treatment services;

4 “(C) evidence of support for the project
5 from the local community to be served by the
6 project;

7 “(D) a description of how the families and
8 leadership of the communities or populations to
9 be served by the project would be involved in
10 the development and ongoing operations of the
11 project;

12 “(E) a plan to involve the tribal commu-
13 nity of the youth who are provided services by
14 the project in planning and evaluating the be-
15 havioral health care and suicide prevention ef-
16 forts provided, in order to ensure the integra-
17 tion of community, clinical, environmental, and
18 cultural components of the treatment; and

19 “(F) a plan for sustaining the project after
20 Federal assistance for the demonstration
21 project has terminated.

22 “(2) EFFICIENCY OF GRANT APPLICATION
23 PROCESS.—The Secretary shall carry out such meas-
24 ures as the Secretary determines to be necessary to
25 maximize the time and workload efficiency of the

1 process by which Indian tribes and tribal organiza-
2 tions apply for grants under paragraph (1).

3 “(d) COLLABORATION.—The Secretary, acting
4 through the Service, shall encourage Indian tribes and
5 tribal organizations receiving grants under this section to
6 collaborate to enable comparisons regarding best practices
7 across projects.

8 “(e) ANNUAL REPORT.—Each grant recipient shall
9 submit to the Secretary an annual report that—

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

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

14 “(f) REPORTS TO CONGRESS.—

15 “(1) INITIAL REPORT.—

16 “(A) IN GENERAL.—Not later than 2 years
17 after the date on which the first grant is award-
18 ed under this section, the Secretary shall sub-
19 mit to the Committee on Indian Affairs of the
20 Senate and the Committee on Natural Re-
21 sources and the Committee on Energy and
22 Commerce of the House of Representatives a
23 report that—

24 “(i) describes each project funded by
25 a grant under this section during the pre-

1 ceding 2-year period, including a descrip-
2 tion of the level of success achieved by the
3 project; and

4 “(ii) evaluates whether the demonstra-
5 tion project should be continued during the
6 period beginning on the date of termi-
7 nation of funding for the demonstration
8 project under subsection (g) and ending on
9 the date on which the final report is sub-
10 mitted under paragraph (2).

11 “(B) CONTINUATION OF DEMONSTRATION
12 PROJECT.—On a determination by the Sec-
13 retary under clause (ii) of subparagraph (A)
14 that the demonstration project should be con-
15 tinued, the Secretary may carry out the dem-
16 onstration project during the period described
17 in that clause using such sums otherwise made
18 available to the Secretary as the Secretary de-
19 termines to be appropriate.

20 “(2) FINAL REPORT.—Not later than 270 days
21 after the date of termination of funding for the dem-
22 onstration project under subsection (g), the Sec-
23 retary shall submit to the Committee on Indian Af-
24 fairs of the Senate and the Committee on Natural
25 Resources and the Committee on Energy and Com-

1 merce of the House of Representatives a final report
2 that—

3 “(A) describes the results of the projects
4 funded by grants awarded under this section,
5 including any data available that indicate the
6 number of attempted suicides;

7 “(B) evaluates the impact of the tele-
8 mental health services funded by the grants in
9 reducing the number of completed suicides
10 among Indian youth;

11 “(C) evaluates whether the demonstration
12 project should be—

13 “(i) expanded to provide more than 5
14 grants; and

15 “(ii) designated as a permanent pro-
16 gram; and

17 “(D) evaluates the benefits of expanding
18 the demonstration project to include urban In-
19 dian organizations.

20 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
21 is authorized to be appropriated to carry out this section
22 \$1,500,000 for each of fiscal years 2010 through 2013.

23 **“SEC. 724. SUBSTANCE ABUSE AND MENTAL HEALTH SERV-
24 ICES ADMINISTRATION GRANTS.**

25 “(a) GRANT APPLICATIONS.—

1 “(1) EFFICIENCY OF GRANT APPLICATION
2 PROCESS.—The Secretary, acting through the Ad-
3 ministration, shall carry out such measures as the
4 Secretary determines to be necessary to maximize
5 the time and workload efficiency of the process by
6 which Indian tribes and tribal organizations apply
7 for grants under any program administered by the
8 Administration, including by providing methods
9 other than electronic methods of submitting applica-
10 tions for those grants, if necessary.

11 “(2) PRIORITY FOR CERTAIN GRANTS.—

12 “(A) IN GENERAL.—To fulfill the trust re-
13 sponsibility of the United States to Indian
14 tribes, in awarding relevant grants pursuant to
15 a program described in subparagraph (B), the
16 Secretary shall take into consideration the
17 needs of Indian tribes or tribal organizations,
18 as applicable, that serve populations with docu-
19 mented high suicide rates, regardless of whether
20 those Indian tribes or tribal organizations pos-
21 sess adequate personnel or infrastructure to ful-
22 fill all applicable requirements of the relevant
23 program.

1 “(B) DESCRIPTION OF GRANT PRO-
2 GRAMS.—A grant program referred to in sub-
3 paragraph (A) is a grant program—

4 “(i) administered by the Administra-
5 tion to fund activities relating to mental
6 health, suicide prevention, or suicide-re-
7 lated risk factors; and

8 “(ii) under which an Indian tribe or
9 tribal organization is an eligible recipient.

10 “(3) CLARIFICATION REGARDING INDIAN
11 TRIBES AND TRIBAL ORGANIZATIONS.—Notwith-
12 standing any other provision of law, in applying for
13 a grant under any program administered by the Ad-
14 ministration, no Indian tribe or tribal organization
15 shall be required to apply through a State or State
16 agency.

17 “(4) REQUIREMENTS FOR AFFECTED
18 STATES.—

19 “(A) DEFINITIONS.—In this paragraph:

20 “(i) AFFECTED STATE.—The term
21 ‘affected State’ means a State—

22 “(I) the boundaries of which in-
23 clude 1 or more Indian tribes; and

24 “(II) the application for a grant
25 under any program administered by

1 the Administration of which includes
2 statewide data.

3 “(ii) INDIAN POPULATION.—The term
4 ‘Indian population’ means the total num-
5 ber of residents of an affected State who
6 are Indian.

7 “(B) REQUIREMENTS.—As a condition of
8 receipt of a grant under any program adminis-
9 tered by the Administration, each affected State
10 shall—

11 “(i) describe in the grant applica-
12 tion—

13 “(I) the Indian population of the
14 affected State; and

15 “(II) the contribution of that In-
16 dian population to the statewide data
17 used by the affected State in the ap-
18 plication; and

19 “(ii) demonstrate to the satisfaction
20 of the Secretary that—

21 “(I) of the total amount of the
22 grant, the affected State will allocate
23 for use for the Indian population of
24 the affected State an amount equal to
25 the proportion that—

1 “(aa) the Indian population
2 of the affected State; bears to

3 “(bb) the total population of
4 the affected State; and

5 “(II) the affected State will take
6 reasonable efforts to collaborate with
7 each Indian tribe located within the
8 affected State to carry out youth sui-
9 cide prevention and treatment meas-
10 ures for members of the Indian tribe.

11 “(C) REPORT.—Not later than 1 year
12 after the date of receipt of a grant described in
13 subparagraph (B), an affected State shall sub-
14 mit to the Secretary a report describing the
15 measures carried out by the affected State to
16 ensure compliance with the requirements of
17 subparagraph (B)(ii).

18 “(b) NO NON-FEDERAL SHARE REQUIREMENT.—
19 Notwithstanding any other provision of law, no Indian
20 tribe or tribal organization shall be required to provide a
21 non-Federal share of the cost of any project or activity
22 carried out using a grant provided under any program ad-
23 ministered by the Administration.

24 “(c) OUTREACH FOR RURAL AND ISOLATED INDIAN
25 TRIBES.—Due to the rural, isolated nature of most Indian

1 reservations and communities (especially those reserva-
2 tions and communities in the Great Plains region), the
3 Secretary shall conduct outreach activities, with a par-
4 ticular emphasis on the provision of telemental health
5 services, to achieve the purposes of this subtitle with re-
6 spect to Indian tribes located in rural, isolated areas.

7 “(d) PROVISION OF OTHER ASSISTANCE.—

8 “(1) IN GENERAL.—The Secretary, acting
9 through the Administration, shall carry out such
10 measures (including monitoring and the provision of
11 required assistance) as the Secretary determines to
12 be necessary to ensure the provision of adequate sui-
13 cide prevention and mental health services to Indian
14 tribes described in paragraph (2), regardless of
15 whether those Indian tribes possess adequate per-
16 sonnel or infrastructure—

17 “(A) to submit an application for a grant
18 under any program administered by the Admin-
19 istration, including due to problems relating to
20 access to the Internet or other electronic means
21 that may have resulted in previous obstacles to
22 submission of a grant application; or

23 “(B) to fulfill all applicable requirements
24 of the relevant program.

1 “(2) DESCRIPTION OF INDIAN TRIBES.—An In-
2 dian tribe referred to in paragraph (1) is an Indian
3 tribe—

4 “(A) the members of which experience—

5 “(i) a high rate of youth suicide;

6 “(ii) low socioeconomic status; and

7 “(iii) extreme health disparity;

8 “(B) that is located in a remote and iso-
9 lated area; and

10 “(C) that lacks technology and commu-
11 nication infrastructure.

12 “(3) AUTHORIZATION OF APPROPRIATIONS.—

13 There are authorized to be appropriated to the Sec-
14 retary such sums as the Secretary determines to be
15 necessary to carry out this subsection.

16 “(e) EARLY INTERVENTION AND ASSESSMENT SERV-
17 ICES.—

18 “(1) DEFINITION OF AFFECTED ENTITY.—In
19 this subsection, the term ‘affected entity’ means any
20 entity—

21 “(A) that receives a grant for suicide inter-
22 vention, prevention, or treatment under a pro-
23 gram administered by the Administration; and

24 “(B) the population to be served by which
25 includes Indian youth.

1 “(2) REQUIREMENT.—The Secretary, acting
2 through the Administration, shall ensure that each
3 affected entity carrying out a youth suicide early
4 intervention and prevention strategy described in
5 section 520E(c)(1) of the Public Health Service Act
6 (42 U.S.C. 290bb–36(c)(1)), or any other youth sui-
7 cide-related early intervention and assessment activ-
8 ity, provides training or education to individuals who
9 interact frequently with the Indian youth to be
10 served by the affected entity (including parents,
11 teachers, coaches, and mentors) on identifying warn-
12 ing signs of Indian youth who are at risk of commit-
13 ting suicide.

14 **“SEC. 725. USE OF PREDOCTORAL PSYCHOLOGY AND PSY-**
15 **CHIATRY INTERNS.**

16 “The Secretary shall carry out such activities as the
17 Secretary determines to be necessary to encourage Indian
18 tribes, tribal organizations, and other mental health care
19 providers to obtain the services of predoctoral psychology
20 and psychiatry interns—

21 “(1) to increase the quantity of patients served
22 by the Indian tribes, tribal organizations, and other
23 mental health care providers; and

24 “(2) for purposes of recruitment and retention.

1 **“SEC. 726. INDIAN YOUTH LIFE SKILLS DEVELOPMENT**
2 **DEMONSTRATION PROGRAM.**

3 “(a) PURPOSE.—The purpose of this section is to au-
4 thorize the Secretary, acting through the Administration,
5 to carry out a demonstration program to test the effective-
6 ness of a culturally compatible, school-based, life skills
7 curriculum for the prevention of Indian and Alaska Native
8 adolescent suicide, including through—

9 “(1) the establishment of tribal partnerships to
10 develop and implement such a curriculum, in co-
11 operation with—

12 “(A) behavioral health professionals, with
13 a priority for tribal partnerships cooperating
14 with mental health professionals employed by
15 the Service;

16 “(B) tribal or local school agencies; and

17 “(C) parent and community groups;

18 “(2) the provision by the Administration or the
19 Service of—

20 “(A) technical expertise; and

21 “(B) clinicians, analysts, and educators, as
22 appropriate;

23 “(3) training for teachers, school administra-
24 tors, and community members to implement the cur-
25 riculum;

1 “(4) the establishment of advisory councils com-
2 posed of parents, educators, community members,
3 trained peers, and others to provide advice regarding
4 the curriculum and other components of the dem-
5 onstration program;

6 “(5) the development of culturally appropriate
7 support measures to supplement the effectiveness of
8 the curriculum; and

9 “(6) projects modeled after evidence-based
10 projects, such as programs evaluated and published
11 in relevant literature.

12 “(b) DEMONSTRATION GRANT PROGRAM.—

13 “(1) DEFINITIONS.—In this subsection:

14 “(A) CURRICULUM.—The term ‘cur-
15 riculum’ means the culturally compatible,
16 school-based, life skills curriculum for the pre-
17 vention of Indian and Alaska Native adolescent
18 suicide identified by the Secretary under para-
19 graph (2)(A).

20 “(B) ELIGIBLE ENTITY.—The term ‘eligi-
21 ble entity’ means—

22 “(i) an Indian tribe;

23 “(ii) a tribal organization;

24 “(iii) any other tribally authorized en-
25 tity; and

1 “(iv) any partnership composed of 2
2 or more entities described in clause (i), (ii),
3 or (iii).

4 “(2) ESTABLISHMENT.—The Secretary, acting
5 through the Administration, may establish and carry
6 out a demonstration program under which the Sec-
7 retary shall—

8 “(A) identify a culturally compatible,
9 school-based, life skills curriculum for the pre-
10 vention of Indian and Alaska Native adolescent
11 suicide;

12 “(B) identify the Indian tribes that are at
13 greatest risk for adolescent suicide;

14 “(C) invite those Indian tribes to partici-
15 pate in the demonstration program by—

16 “(i) responding to a comprehensive
17 program requirement request of the Sec-
18 retary; or

19 “(ii) submitting, through an eligible
20 entity, an application in accordance with
21 paragraph (4); and

22 “(D) provide grants to the Indian tribes
23 identified under subparagraph (B) and eligible
24 entities to implement the curriculum with re-

1 spect to Indian and Alaska Native youths
2 who—

3 “(i) are between the ages of 10 and
4 19; and

5 “(ii) attend school in a region that is
6 at risk of high youth suicide rates, as de-
7 termined by the Administration.

8 “(3) REQUIREMENTS.—

9 “(A) TERM.—The term of a grant pro-
10 vided under the demonstration program under
11 this section shall be not less than 4 years.

12 “(B) MAXIMUM NUMBER.—The Secretary
13 may provide not more than 5 grants under the
14 demonstration program under this section.

15 “(C) AMOUNT.—The grants provided
16 under this section shall be of equal amounts.

17 “(D) CERTAIN SCHOOLS.—In selecting eli-
18 gible entities to receive grants under this sec-
19 tion, the Secretary shall ensure that not less
20 than 1 demonstration program shall be carried
21 out at each of—

22 “(i) a school operated by the Bureau
23 of Indian Education;

24 “(ii) a Tribal school; and

1 “(iii) a school receiving payments
2 under section 8002 or 8003 of the Elemen-
3 tary and Secondary Education Act of 1965
4 (20 U.S.C. 7702, 7703).

5 “(4) APPLICATIONS.—To be eligible to receive a
6 grant under the demonstration program, an eligible
7 entity shall submit to the Secretary an application,
8 at such time, in such manner, and containing such
9 information as the Secretary may require, includ-
10 ing—

11 “(A) an assurance that, in implementing
12 the curriculum, the eligible entity will collabo-
13 rate with 1 or more local educational agencies,
14 including elementary schools, middle schools,
15 and high schools;

16 “(B) an assurance that the eligible entity
17 will collaborate, for the purpose of curriculum
18 development, implementation, and training and
19 technical assistance, with 1 or more—

20 “(i) nonprofit entities with dem-
21 onstrated expertise regarding the develop-
22 ment of culturally sensitive, school-based,
23 youth suicide prevention and intervention
24 programs; or

1 “(iii) depression and other relevant
2 mental health concerns.

3 “(5) USE OF FUNDS.—An Indian tribe identi-
4 fied under paragraph (2)(B) or an eligible entity
5 may use a grant provided under this subsection—

6 “(A) to develop and implement the cur-
7 riculum in a school-based setting;

8 “(B) to establish an advisory council—

9 “(i) to advise the Indian tribe or eligi-
10 ble entity regarding curriculum develop-
11 ment; and

12 “(ii) to provide support services iden-
13 tified as necessary by the community being
14 served by the Indian tribe or eligible enti-
15 ty;

16 “(C) to appoint and train a school- and
17 community-based cultural resource liaison, who
18 will act as an intermediary among the Indian
19 tribe or eligible entity, the applicable school ad-
20 ministrators, and the advisory council estab-
21 lished by the Indian tribe or eligible entity;

22 “(D) to establish an on-site, school-based,
23 MA- or PhD-level mental health practitioner
24 (employed by the Service, if practicable) to
25 work with tribal educators and other personnel;

1 “(E) to provide for the training of peer
2 counselors to assist in carrying out the cur-
3 rriculum;

4 “(F) to procure technical and training sup-
5 port from nonprofit or State entities or institu-
6 tions of higher education identified by the com-
7 munity being served by the Indian tribe or eligi-
8 ble entity as the best suited to develop and im-
9 plement the curriculum;

10 “(G) to train teachers and school adminis-
11 trators to effectively carry out the curriculum;

12 “(H) to establish an effective referral pro-
13 cedure and network;

14 “(I) to identify and develop culturally com-
15 patible curriculum support measures;

16 “(J) to obtain educational materials and
17 other resources from the Administration or
18 other appropriate entities to ensure the success
19 of the demonstration program; and

20 “(K) to evaluate the effectiveness of the
21 curriculum in preventing Indian and Alaska
22 Native adolescent suicide.

23 “(c) EVALUATIONS.—Using such amounts made
24 available pursuant to subsection (e) as the Secretary de-
25 termines to be appropriate, the Secretary shall conduct,

1 directly or through a grant, contract, or cooperative agree-
2 ment with an entity that has experience regarding the de-
3 velopment and operation of successful culturally compat-
4 ible, school-based, life skills suicide prevention and inter-
5 vention programs or evaluations, an annual evaluation of
6 the demonstration program under this section, including
7 an evaluation of—

8 “(1) the effectiveness of the curriculum in pre-
9 venting Indian and Alaska Native adolescent suicide;

10 “(2) areas for program improvement; and

11 “(3) additional development of the goals and
12 objectives of the demonstration program.

13 “(d) REPORT TO CONGRESS.—

14 “(1) IN GENERAL.—Subject to paragraph (2),
15 not later than 180 days after the date of termination
16 of the demonstration program, the Secretary shall
17 submit to the Committee on Indian Affairs and the
18 Committee on Health, Education, Labor, and Pen-
19 sions of the Senate and the Committee on Natural
20 Resources and the Committee on Education and
21 Labor of the House of Representatives a final report
22 that—

23 “(A) describes the results of the program
24 of each Indian tribe or eligible entity under this
25 section;

1 “(B) evaluates the effectiveness of the cur-
2 riculum in preventing Indian and Alaska Native
3 adolescent suicide;

4 “(C) makes recommendations regarding—

5 “(i) the expansion of the demonstra-
6 tion program under this section to addi-
7 tional eligible entities;

8 “(ii) designating the demonstration
9 program as a permanent program; and

10 “(iii) identifying and distributing the
11 curriculum through the Suicide Prevention
12 Resource Center of the Administration;
13 and

14 “(D) incorporates any public comments re-
15 ceived under paragraph (2).

16 “(2) PUBLIC COMMENT.—The Secretary shall
17 provide a notice of the report under paragraph (1)
18 and an opportunity for public comment on the re-
19 port for a period of not less than 90 days before
20 submitting the report to Congress.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section
23 \$1,000,000 for each of fiscal years 2010 through 2014.”.

1 **Subtitle H—Miscellaneous**

2 **SEC. 191. CONFIDENTIALITY OF MEDICAL QUALITY ASSUR-**
3 **ANCE RECORDS; QUALIFIED IMMUNITY FOR**
4 **PARTICIPANTS.**

5 Title VIII of the Indian Health Care Improvement
6 Act (as amended by section 101(b)) is amended by insert-
7 ing after section 804 (25 U.S.C. 1674) the following:

8 **“SEC. 805. CONFIDENTIALITY OF MEDICAL QUALITY ASSUR-**
9 **ANCE RECORDS; QUALIFIED IMMUNITY FOR**
10 **PARTICIPANTS.**

11 “(a) DEFINITIONS.—In this section:

12 “(1) HEALTH CARE PROVIDER.—The term
13 ‘health care provider’ means any health care profes-
14 sional, including community health aides and practi-
15 tioners certified under section 119, who is—

16 “(A) granted clinical practice privileges or
17 employed to provide health care services at—

18 “(i) an Indian health program; or

19 “(ii) a health program of an urban In-
20 dian organization; and

21 “(B) licensed or certified to perform health
22 care services by a governmental board or agen-
23 cy or professional health care society or organi-
24 zation.

1 “(2) MEDICAL QUALITY ASSURANCE PRO-
2 GRAM.—The term ‘medical quality assurance pro-
3 gram’ means any activity carried out before, on, or
4 after the date of enactment of the Indian Health
5 Care Improvement Reauthorization and Extension
6 Act of 2009 by or for any Indian health program or
7 urban Indian organization to assess the quality of
8 medical care, including activities conducted by or on
9 behalf of individuals, Indian health program or
10 urban Indian organization medical or dental treat-
11 ment review committees, or other review bodies re-
12 sponsible for quality assurance, credentials, infection
13 control, patient safety, patient care assessment (in-
14 cluding treatment procedures, blood, drugs, and
15 therapeutics), medical records, health resources
16 management review, and identification and preven-
17 tion of medical or dental incidents and risks.

18 “(3) MEDICAL QUALITY ASSURANCE RECORD.—
19 The term ‘medical quality assurance record’ means
20 the proceedings, records, minutes, and reports
21 that—

22 “(A) emanate from quality assurance pro-
23 gram activities described in paragraph (2); and

24 “(B) are produced or compiled by or for an
25 Indian health program or urban Indian organi-

1 zation as part of a medical quality assurance
2 program.

3 “(b) CONFIDENTIALITY OF RECORDS.—Medical qual-
4 ity assurance records created by or for any Indian health
5 program or a health program of an urban Indian organiza-
6 tion as part of a medical quality assurance program are
7 confidential and privileged. Such records may not be dis-
8 closed to any person or entity, except as provided in sub-
9 section (d).

10 “(c) PROHIBITION ON DISCLOSURE AND TESTI-
11 MONY.—

12 “(1) IN GENERAL.—No part of any medical
13 quality assurance record described in subsection (b)
14 may be subject to discovery or admitted into evi-
15 dence in any judicial or administrative proceeding,
16 except as provided in subsection (d).

17 “(2) TESTIMONY.—An individual who reviews
18 or creates medical quality assurance records for any
19 Indian health program or urban Indian organization
20 who participates in any proceeding that reviews or
21 creates such records may not be permitted or re-
22 quired to testify in any judicial or administrative
23 proceeding with respect to such records or with re-
24 spect to any finding, recommendation, evaluation,
25 opinion, or action taken by such person or body in

1 connection with such records except as provided in
2 this section.

3 “(d) AUTHORIZED DISCLOSURE AND TESTIMONY.—

4 “(1) IN GENERAL.—Subject to paragraph (2), a
5 medical quality assurance record described in sub-
6 section (b) may be disclosed, and an individual re-
7 ferred to in subsection (c) may give testimony in
8 connection with such a record, only as follows:

9 “(A) To a Federal agency or private orga-
10 nization, if such medical quality assurance
11 record or testimony is needed by such agency or
12 organization to perform licensing or accredita-
13 tion functions related to any Indian health pro-
14 gram or to a health program of an urban In-
15 dian organization to perform monitoring, re-
16 quired by law, of such program or organization.

17 “(B) To an administrative or judicial pro-
18 ceeding commenced by a present or former In-
19 dian health program or urban Indian organiza-
20 tion provider concerning the termination, sus-
21 pension, or limitation of clinical privileges of
22 such health care provider.

23 “(C) To a governmental board or agency
24 or to a professional health care society or orga-
25 nization, if such medical quality assurance

1 record or testimony is needed by such board,
2 agency, society, or organization to perform li-
3 censing, credentialing, or the monitoring of pro-
4 fessional standards with respect to any health
5 care provider who is or was an employee of any
6 Indian health program or urban Indian organi-
7 zation.

8 “(D) To a hospital, medical center, or
9 other institution that provides health care serv-
10 ices, if such medical quality assurance record or
11 testimony is needed by such institution to as-
12 sess the professional qualifications of any health
13 care provider who is or was an employee of any
14 Indian health program or urban Indian organi-
15 zation and who has applied for or been granted
16 authority or employment to provide health care
17 services in or on behalf of such program or or-
18 ganization.

19 “(E) To an officer, employee, or contractor
20 of the Indian health program or urban Indian
21 organization that created the records or for
22 which the records were created. If that officer,
23 employee, or contractor has a need for such
24 record or testimony to perform official duties.

1 “(F) To a criminal or civil law enforce-
2 ment agency or instrumentality charged under
3 applicable law with the protection of the public
4 health or safety, if a qualified representative of
5 such agency or instrumentality makes a written
6 request that such record or testimony be pro-
7 vided for a purpose authorized by law.

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

13 “(2) IDENTITY OF PARTICIPANTS.—With the
14 exception of the subject of a quality assurance ac-
15 tion, the identity of any person receiving health care
16 services from any Indian health program or urban
17 Indian organization or the identity of any other per-
18 son associated with such program or organization
19 for purposes of a medical quality assurance program
20 that is disclosed in a medical quality assurance
21 record described in subsection (b) shall be deleted
22 from that record or document before any disclosure
23 of such record is made outside such program or or-
24 ganization.

25 “(e) DISCLOSURE FOR CERTAIN PURPOSES.—

1 “(1) IN GENERAL.—Nothing in this section
2 shall be construed as authorizing or requiring the
3 withholding from any person or entity aggregate sta-
4 tistical information regarding the results of any In-
5 dian health program or urban Indian organization’s
6 medical quality assurance programs.

7 “(2) WITHHOLDING FROM CONGRESS.—Noth-
8 ing in this section shall be construed as authority to
9 withhold any medical quality assurance record from
10 a committee of either House of Congress, any joint
11 committee of Congress, or the Government Account-
12 ability Office if such record pertains to any matter
13 within their respective jurisdictions.

14 “(f) PROHIBITION ON DISCLOSURE OF RECORD OR
15 TESTIMONY.—An individual or entity having possession of
16 or access to a record or testimony described by this section
17 may not disclose the contents of such record or testimony
18 in any manner or for any purpose except as provided in
19 this section.

20 “(g) EXEMPTION FROM FREEDOM OF INFORMATION
21 ACT.—Medical quality assurance records described in sub-
22 section (b) may not be made available to any person under
23 section 552 of title 5, United States Code.

24 “(h) LIMITATION ON CIVIL LIABILITY.—An indi-
25 vidual who participates in or provides information to a

1 person or body that reviews or creates medical quality as-
2 surance records described in subsection (b) shall not be
3 civilly liable for such participation or for providing such
4 information if the participation or provision of information
5 was in good faith based on prevailing professional stand-
6 ards at the time the medical quality assurance program
7 activity took place.

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

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

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

24 “(l) INCONSISTENCIES.—To the extent that the pro-
25 tections under part C of title IX of the Public Health Serv-

1 ice Act (42 U.S.C. 229b–21 et seq.) (as amended by the
2 Patient Safety and Quality Improvement Act of 2005
3 (Public Law 109–41; 119 Stat. 424)) and this section are
4 inconsistent, the provisions of whichever is more protective
5 shall control.

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

11 **SEC. 192. ARIZONA, NORTH DAKOTA, AND SOUTH DAKOTA**
12 **AS CONTRACT HEALTH SERVICE DELIVERY**
13 **AREAS; ELIGIBILITY OF CALIFORNIA INDI-**
14 **ANS.**

15 Title VIII of the Indian Health Care Improvement
16 Act is amended—

17 (1) by striking section 808 (25 U.S.C. 1678)
18 and inserting the following:

19 **“SEC. 808. ARIZONA AS CONTRACT HEALTH SERVICE DELIV-**
20 **ERY AREA.**

21 “(a) IN GENERAL.—The State of Arizona shall be
22 designated as a contract health service delivery area by
23 the Service for the purpose of providing contract health
24 care services to members of Indian tribes in the State of
25 Arizona.

1 **“SEC. 809. ELIGIBILITY OF CALIFORNIA INDIANS.**

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

4 “(1) Any member of a federally recognized In-
5 dian tribe.

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

9 “(A) is a member of the Indian community
10 served by a local program of the Service; and

11 “(B) is regarded as an Indian by the com-
12 munity in which such descendant lives.

13 “(3) Any Indian who holds trust interests in
14 public domain, national forest, or reservation allot-
15 ments in California.

16 “(4) Any Indian of California who is listed on
17 the plans for distribution of the assets of rancherias
18 and reservations located within the State of Cali-
19 fornia under the Act of August 18, 1958 (72 Stat.
20 619), and any descendant of such an Indian.

21 “(b) CLARIFICATION.—Nothing in this section may
22 be construed as expanding the eligibility of California Indi-
23 ans for health services provided by the Service beyond the
24 scope of eligibility for such health services that applied on
25 May 1, 1986.”.

1 **SEC. 193. METHODS TO INCREASE ACCESS TO PROFES-**
2 **SIONALS OF CERTAIN CORPS.**

3 Section 812 of the Indian Health Care Improvement
4 Act (25 U.S.C. 1680b) is amended to read as follows:

5 **“SEC. 812. NATIONAL HEALTH SERVICE CORPS.**

6 “(a) NO REDUCTION IN SERVICES.—The Secretary
7 shall not remove a member of the National Health Service
8 Corps from an Indian health program or urban Indian or-
9 ganization or withdraw funding used to support such a
10 member, unless the Secretary, acting through the Service,
11 has ensured that the Indians receiving services from the
12 member will experience no reduction in services.

13 “(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—
14 At the request of an Indian health program, the services
15 of a member of the National Health Service Corps as-
16 signed to the Indian health program may be limited to
17 the individuals who are eligible for services from that In-
18 dian health program.”.

19 **SEC. 194. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

20 Section 813 of the Indian Health Care Improvement
21 Act (25 U.S.C. 1680c) is amended to read as follows:

22 **“SEC. 813. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

23 “(a) CHILDREN.—Any individual who—

24 “(1) has not attained 19 years of age;

1 “(2) is the natural or adopted child, stepchild,
2 foster child, legal ward, or orphan of an eligible In-
3 dian; and

4 “(3) is not otherwise eligible for health services
5 provided by the Service,
6 shall be eligible for all health services provided by the
7 Service on the same basis and subject to the same rules
8 that apply to eligible Indians until such individual attains
9 19 years of age. The existing and potential health needs
10 of all such individuals shall be taken into consideration
11 by the Service in determining the need for, or the alloca-
12 tion of, the health resources of the Service. If such an indi-
13 vidual has been determined to be legally incompetent prior
14 to attaining 19 years of age, such individual shall remain
15 eligible for such services until 1 year after the date of a
16 determination of competency.

17 “(b) SPOUSES.—Any spouse of an eligible Indian who
18 is not an Indian, or who is of Indian descent but is not
19 otherwise eligible for the health services provided by the
20 Service, shall be eligible for such health services if all such
21 spouses or spouses who are married to members of each
22 Indian tribe being served are made eligible, as a class, by
23 an appropriate resolution of the governing body of the In-
24 dian tribe or tribal organization providing such services.
25 The health needs of persons made eligible under this para-

1 graph shall not be taken into consideration by the Service
2 in determining the need for, or allocation of, its health
3 resources.

4 “(c) HEALTH FACILITIES PROVIDING HEALTH
5 SERVICES.—

6 “(1) IN GENERAL.—The Secretary is authorized
7 to provide health services under this subsection
8 through health facilities operated directly by the
9 Service to individuals who reside within the Service
10 unit and who are not otherwise eligible for such
11 health services if—

12 “(A) the Indian tribes served by such Serv-
13 ice unit requests such provision of health serv-
14 ices to such individuals, and

15 “(B) the Secretary and the served Indian
16 tribes have jointly determined that the provision
17 of such health services will not result in a de-
18 nial or diminution of health services to eligible
19 Indians.

20 “(2) ISDEAA PROGRAMS.—In the case of
21 health facilities operated under a contract or com-
22 pact entered into under the Indian Self-Determina-
23 tion and Education Assistance Act (25 U.S.C. 450
24 et seq.), the governing body of the Indian tribe or
25 tribal organization providing health services under

1 such contract or compact is authorized to determine
2 whether health services should be provided under
3 such contract or compact to individuals who are not
4 eligible for such health services under any other sub-
5 section of this section or under any other provision
6 of law. In making such determinations, the gov-
7 erning body of the Indian tribe or tribal organization
8 shall take into account the consideration described in
9 paragraph (1)(B). Any services provided by the In-
10 dian tribe or tribal organization pursuant to a deter-
11 mination made under this subparagraph shall be
12 deemed to be provided under the agreement entered
13 into by the Indian tribe or tribal organization under
14 the Indian Self-Determination and Education Assist-
15 ance Act. The provisions of section 314 of Public
16 Law 101–512 (104 Stat. 1959), as amended by sec-
17 tion 308 of Public Law 103–138 (107 Stat. 1416),
18 shall apply to any services provided by the Indian
19 tribe or tribal organization pursuant to a determina-
20 tion made under this subparagraph.

21 “(3) PAYMENT FOR SERVICES.—

22 “(A) IN GENERAL.—Persons receiving
23 health services provided by the Service under
24 this subsection shall be liable for payment of
25 such health services under a schedule of charges

1 prescribed by the Secretary which, in the judg-
2 ment of the Secretary, results in reimbursement
3 in an amount not less than the actual cost of
4 providing the health services. Notwithstanding
5 section 207 of this Act or any other provision
6 of law, amounts collected under this subsection,
7 including Medicare, Medicaid, or children's
8 health insurance program reimbursements
9 under titles XVIII, XIX, and XXI of the Social
10 Security Act (42 U.S.C. 1395 et seq.), shall be
11 credited to the account of the program pro-
12 viding the service and shall be used for the pur-
13 poses listed in section 401(d)(2) and amounts
14 collected under this subsection shall be available
15 for expenditure within such program.

16 “(B) INDIGENT PEOPLE.—Health services
17 may be provided by the Secretary through the
18 Service under this subsection to an indigent in-
19 dividual who would not be otherwise eligible for
20 such health services but for the provisions of
21 paragraph (1) only if an agreement has been
22 entered into with a State or local government
23 under which the State or local government
24 agrees to reimburse the Service for the expenses

1 incurred by the Service in providing such health
2 services to such indigent individual.

3 “(4) REVOCATION OF CONSENT FOR SERV-
4 ICES.—

5 “(A) SINGLE TRIBE SERVICE AREA.—In
6 the case of a Service Area which serves only 1
7 Indian tribe, the authority of the Secretary to
8 provide health services under paragraph (1)
9 shall terminate at the end of the fiscal year suc-
10 ceeding the fiscal year in which the governing
11 body of the Indian tribe revokes its concurrence
12 to the provision of such health services.

13 “(B) MULTITRIBAL SERVICE AREA.—In
14 the case of a multitribal Service Area, the au-
15 thority of the Secretary to provide health serv-
16 ices under paragraph (1) shall terminate at the
17 end of the fiscal year succeeding the fiscal year
18 in which at least 51 percent of the number of
19 Indian tribes in the Service Area revoke their
20 concurrence to the provisions of such health
21 services.

22 “(d) OTHER SERVICES.—The Service may provide
23 health services under this subsection to individuals who
24 are not eligible for health services provided by the Service
25 under any other provision of law in order to—

1 “(1) achieve stability in a medical emergency;

2 “(2) prevent the spread of a communicable dis-
3 ease or otherwise deal with a public health hazard;

4 “(3) provide care to non-Indian women preg-
5 nant with an eligible Indian’s child for the duration
6 of the pregnancy through postpartum; or

7 “(4) provide care to immediate family members
8 of an eligible individual if such care is directly re-
9 lated to the treatment of the eligible individual.

10 “(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

11 “(1) IN GENERAL.—Hospital privileges in
12 health facilities operated and maintained by the
13 Service or operated under a contract or compact
14 pursuant to the Indian Self-Determination and Edu-
15 cation Assistance Act (25 U.S.C. 450 et seq.) may
16 be extended to non-Service health care practitioners
17 who provide services to individuals described in sub-
18 section (a), (b), (c), or (d). Such non-Service health
19 care practitioners may, as part of the privileging
20 process, be designated as employees of the Federal
21 Government for purposes of section 1346(b) and
22 chapter 171 of title 28, United States Code (relating
23 to Federal tort claims) only with respect to acts or
24 omissions which occur in the course of providing
25 services to eligible individuals as a part of the condi-

1 tions under which such hospital privileges are ex-
2 tended.

3 “(2) DEFINITION.—For purposes of this sub-
4 section, the term ‘non-Service health care practi-
5 tioner’ means a practitioner who is not—

6 “(A) an employee of the Service; or

7 “(B) an employee of an Indian tribe or
8 tribal organization operating a contract or com-
9 pact under the Indian Self-Determination and
10 Education Assistance Act (25 U.S.C. 450 et
11 seq.) or an individual who provides health care
12 services pursuant to a personal services con-
13 tract with such Indian tribe or tribal organiza-
14 tion.

15 “(f) ELIGIBLE INDIAN.—For purposes of this sec-
16 tion, the term ‘eligible Indian’ means any Indian who is
17 eligible for health services provided by the Service without
18 regard to the provisions of this section.”.

19 **SEC. 195. ANNUAL BUDGET SUBMISSION.**

20 Title VIII of the Indian Health Care Improvement
21 Act (25 U.S.C. 1671 et seq.) is amended by adding at
22 the end the following:

23 **“SEC. 826. ANNUAL BUDGET SUBMISSION.**

24 “Effective beginning with the submission of the an-
25 nual budget request to Congress for fiscal year 2011, the

1 President shall include, in the amount requested and the
2 budget justification, amounts that reflect any changes
3 in—

4 “(1) the cost of health care services, as indexed
5 for United States dollar inflation (as measured by
6 the Consumer Price Index); and

7 “(2) the size of the population served by the
8 Service.”.

9 **SEC. 196. PRESCRIPTION DRUG MONITORING.**

10 Title VIII of the Indian Health Care Improvement
11 Act (25 U.S.C. 1671 et seq.) (as amended by section 195)
12 is amended by adding at the end the following:

13 **“SEC. 827. PRESCRIPTION DRUG MONITORING.**

14 “(a) MONITORING.—

15 “(1) ESTABLISHMENT.—The Secretary, in co-
16 ordination with the Secretary of the Interior and the
17 Attorney General, shall establish a prescription drug
18 monitoring program, to be carried out at health care
19 facilities of the Service, tribal health care facilities,
20 and urban Indian health care facilities.

21 “(2) REPORT.—Not later than 18 months after
22 the date of enactment of the Indian Health Care Im-
23 provement Reauthorization and Extension Act of
24 2009, the Secretary shall submit to the Committee
25 on Indian Affairs of the Senate and the Committee

1 on Natural Resources of the House of Representa-
2 tives a report that describes—

3 “(A) the needs of the Service, tribal health
4 care facilities, and urban Indian health care fa-
5 cilities with respect to the prescription drug
6 monitoring program under paragraph (1);

7 “(B) the planned development of that pro-
8 gram, including any relevant statutory or ad-
9 ministrative limitations; and

10 “(C) the means by which the program
11 could be carried out in coordination with any
12 State prescription drug monitoring program.

13 “(b) ABUSE.—

14 “(1) IN GENERAL.—The Attorney General, in
15 conjunction with the Secretary and the Secretary of
16 the Interior, shall conduct—

17 “(A) an assessment of the capacity of, and
18 support required by, relevant Federal and tribal
19 agencies—

20 “(i) to carry out data collection and
21 analysis regarding incidents of prescription
22 drug abuse in Indian communities; and

23 “(ii) to exchange among those agen-
24 cies and Indian health programs informa-
25 tion relating to prescription drug abuse in

1 Indian communities, including statutory
2 and administrative requirements and limi-
3 tations relating to that abuse; and

4 “(B) training for Indian health care pro-
5 viders, tribal leaders, law enforcement officers,
6 and school officials regarding awareness and
7 prevention of prescription drug abuse and strat-
8 egies for improving agency responses to ad-
9 dressing prescription drug abuse in Indian com-
10 munities.

11 “(2) REPORT.—Not later than 18 months after
12 the date of enactment of the Indian Health Care Im-
13 provement Reauthorization and Extension Act of
14 2009, the Attorney General shall submit to the Com-
15 mittee on Indian Affairs of the Senate and the Com-
16 mittee on Natural Resources of the House of Rep-
17 resentatives a report that describes—

18 “(A) the capacity of Federal and tribal
19 agencies to carry out data collection and anal-
20 ysis and information exchanges as described in
21 paragraph (1)(A);

22 “(B) the training conducted pursuant to
23 paragraph (1)(B);

1 “(C) infrastructure enhancements required
2 to carry out the activities described in para-
3 graph (1), if any; and

4 “(D) any statutory or administrative bar-
5 riers to carrying out those activities.”.

6 **SEC. 197. TRIBAL HEALTH PROGRAM OPTION FOR COST**
7 **SHARING.**

8 Title VIII of the Indian Health Care Improvement
9 Act (25 U.S.C. 1671 et seq.) (as amended by section 196)
10 is amended by adding at the end the following:

11 **“SEC. 828. TRIBAL HEALTH PROGRAM OPTION FOR COST**
12 **SHARING.**

13 “(a) IN GENERAL.—Nothing in this Act limits the
14 ability of a tribal health program operating any health
15 program, service, function, activity, or facility funded, in
16 whole or part, by the Service through, or provided for in,
17 a compact with the Service pursuant to title V of the In-
18 dian Self-Determination and Education Assistance Act
19 (25 U.S.C. 458aaa et seq.) to charge an Indian for serv-
20 ices provided by the tribal health program.

21 “(b) SERVICE.—Nothing in this Act authorizes the
22 Service—

23 “(1) to charge an Indian for services; or

24 “(2) to require any tribal health program to
25 charge an Indian for services.”.

1 **SEC. 198. DISEASE AND INJURY PREVENTION REPORT.**

2 Title VIII of the Indian Health Care Improvement
3 Act (25 U.S.C. 1671 et seq.) (as amended by section 197)
4 is amended by adding at the end the following:

5 **“SEC. 829. DISEASE AND INJURY PREVENTION REPORT.**

6 “Not later than 18 months after the date of enact-
7 ment of the Indian Health Care Improvement Reauthor-
8 ization and Extension Act of 2009, the Secretary shall
9 submit to the Committee on Indian Affairs of the Senate
10 and the Committees on Natural Resources and Energy
11 and Commerce of the House of Representatives describ-
12 ing—

13 “(1) all disease and injury prevention activities
14 conducted by the Service, independently or in con-
15 junction with other Federal departments and agen-
16 cies and Indian tribes; and

17 “(2) the effectiveness of those activities, includ-
18 ing the reductions of injury or disease conditions
19 achieved by the activities.”.

20 **SEC. 199. OTHER GAO REPORTS.**

21 Title VIII of the Indian Health Care Improvement
22 Act (25 U.S.C. 1671 et seq.) (as amended by section 198)
23 is amended by adding at the end the following:

24 **“SEC. 830. OTHER GAO REPORTS.**

25 “(a) COORDINATION OF SERVICES.—

1 “(1) STUDY AND EVALUATION.—The Comp-
2 troller General of the United States shall conduct a
3 study, and evaluate the effectiveness, of coordination
4 of health care services provided to Indians—

5 “(A) through Medicare, Medicaid, or
6 SCHIP;

7 “(B) by the Service; or

8 “(C) using funds provided by—

9 “(i) State or local governments; or

10 “(ii) Indian tribes.

11 “(2) REPORT.—Not later than 18 months after
12 the date of enactment of the Indian Health Care Im-
13 provement Reauthorization and Extension Act of
14 2009, the Comptroller General shall submit to Con-
15 gress a report—

16 “(A) describing the results of the evalua-
17 tion under paragraph (1); and

18 “(B) containing recommendations of the
19 Comptroller General regarding measures to
20 support and increase coordination of the provi-
21 sion of health care services to Indians as de-
22 scribed in paragraph (1).

23 “(b) PAYMENTS FOR CONTRACT HEALTH SERV-
24 ICES.—

1 “(1) IN GENERAL.—The Comptroller General
2 shall conduct a study on the use of health care fur-
3 nished by health care providers under the contract
4 health services program funded by the Service and
5 operated by the Service, an Indian tribe, or a tribal
6 organization.

7 “(2) ANALYSIS.—The study conducted under
8 paragraph (1) shall include an analysis of—

9 “(A) the amounts reimbursed under the
10 contract health services program described in
11 paragraph (1) for health care furnished by enti-
12 ties, individual providers, and suppliers, includ-
13 ing a comparison of reimbursement for that
14 health care through other public programs and
15 in the private sector;

16 “(B) barriers to accessing care under such
17 contract health services program, including bar-
18 riers relating to travel distances, cultural dif-
19 ferences, and public and private sector reluc-
20 tance to furnish care to patients under the pro-
21 gram;

22 “(C) the adequacy of existing Federal
23 funding for health care under the contract
24 health services program;

1 “(D) the administration of the contract
2 health service program, including the distribu-
3 tion of funds to Indian health programs pursu-
4 ant to the program; and

5 “(E) any other items determined appro-
6 priate by the Comptroller General.

7 “(3) REPORT.—Not later than 18 months after
8 the date of enactment of the Indian Health Care Im-
9 provement Reauthorization and Extension Act of
10 2009, the Comptroller General shall submit to Con-
11 gress a report on the study conducted under para-
12 graph (1), together with recommendations regard-
13 ing—

14 “(A) the appropriate level of Federal fund-
15 ing that should be established for health care
16 under the contract health services program de-
17 scribed in paragraph (1);

18 “(B) how to most efficiently use that fund-
19 ing; and

20 “(C) the identification of any inequities in
21 the current distribution formula or inequitable
22 results for any Indian tribe under the funding
23 level, and any recommendations for addressing
24 any inequities or inequitable results identified.

1 “(4) CONSULTATION.—In conducting the study
2 under paragraph (1) and preparing the report under
3 paragraph (3), the Comptroller General shall consult
4 with the Service, Indian tribes, and tribal organiza-
5 tions.”.

6 **SEC. 199A. TRADITIONAL HEALTH CARE PRACTICES.**

7 Title VIII of the Indian Health Care Improvement
8 Act (25 U.S.C. 1671 et seq.) (as amended by section 199)
9 is amended by adding at the end the following:

10 **“SEC. 831. TRADITIONAL HEALTH CARE PRACTICES.**

11 “Although the Secretary may promote traditional
12 health care practices, consistent with the Service stand-
13 ards for the provision of health care, health promotion,
14 and disease prevention under this Act, the United States
15 is not liable for any provision of traditional health care
16 practices pursuant to this Act that results in damage, in-
17 jury, or death to a patient. Nothing in this subsection shall
18 be construed to alter any liability or other obligation that
19 the United States may otherwise have under the Indian
20 Self-Determination and Education Assistance Act (25
21 U.S.C. 450 et seq.) or this Act.”.

1 **SEC. 199B. DIRECTOR OF HIV/AIDS PREVENTION AND**
2 **TREATMENT.**

3 Title VIII of the Indian Health Care Improvement
4 Act (25 U.S.C. 1671 et seq.) (as amended by section
5 199A) is amended by adding at the end the following:

6 **“SEC. 832. DIRECTOR OF HIV/AIDS PREVENTION AND**
7 **TREATMENT.**

8 “(a) ESTABLISHMENT.—The Secretary, acting
9 through the Service, shall establish within the Service the
10 position of the Director of HIV/AIDS Prevention and
11 Treatment (referred to in this section as the ‘Director’).

12 “(b) DUTIES.—The Director shall—

13 “(1) coordinate and promote HIV/AIDS preven-
14 tion and treatment activities specific to Indians;

15 “(2) provide technical assistance to Indian
16 tribes, tribal organizations, and urban Indian orga-
17 nizations regarding existing HIV/AIDS prevention
18 and treatment programs; and

19 “(3) ensure interagency coordination to facili-
20 tate the inclusion of Indians in Federal HIV/AIDS
21 research and grant opportunities, with emphasis on
22 the programs operated under the Ryan White Com-
23 prehensive Aids Resources Emergency Act of 1990
24 (Public Law 101–381; 104 Stat. 576) and the
25 amendments made by that Act.

1 “(c) REPORT.—Not later than 2 years after the date
2 of enactment of the Indian Health Care Improvement Re-
3 authorization and Extension Act of 2009, and not less fre-
4 quently than once every 2 years thereafter, the Director
5 shall submit to Congress a report describing, with respect
6 to the preceding 2-year period—

7 “(1) each activity carried out under this sec-
8 tion; and

9 “(2) any findings of the Director with respect
10 to HIV/AIDS prevention and treatment activities
11 specific to Indians.”.

12 **TITLE II—AMENDMENTS TO** 13 **OTHER ACTS**

14 **SEC. 201. MEDICARE AMENDMENTS.**

15 (a) IN GENERAL.—Section 1880 of the Social Secu-
16 rity Act (42 U.S.C. 1395qq) is amended—

17 (1) by redesignating subsection (f) as sub-
18 section (g); and

19 (2) by inserting after subsection (e) the fol-
20 lowing:

21 “(f) PROHIBITION.—Payments made pursuant to this
22 section shall not be reduced as a result of any beneficiary
23 deductible, coinsurance, or other charge under section
24 1813.”.

1 (b) PAYMENT OF BENEFITS.—Section 1833(a)(1)(B)
2 of the Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is
3 amended by inserting “or 1880(e)” after “section
4 1861(s)(10)(A)”.

5 **SEC. 202. REAUTHORIZATION OF NATIVE HAWAIIAN**
6 **HEALTH CARE PROGRAMS.**

7 (a) REAUTHORIZATION.—The Native Hawaiian
8 Health Care Act of 1988 (42 U.S.C. 11701 et seq.) is
9 amended by striking “2001” each place it appears in sec-
10 tions 6(h)(1), 7(b), and 10(c) (42 U.S.C. 11705(h)(1),
11 11706(b), 11709(c)) and inserting “2019”.

12 (b) HEALTH AND EDUCATION.—

13 (1) IN GENERAL.—Section 6(e) of the Native
14 Hawaiian Health Care Act of 1988 (42 U.S.C.
15 11705) is amended by adding at the end the fol-
16 lowing:

17 “(4) HEALTH AND EDUCATION.—In order to
18 enable privately funded organizations to continue to
19 supplement public efforts to provide educational pro-
20 grams designed to improve the health, capability,
21 and well-being of Native Hawaiians and to continue
22 to provide health services to Native Hawaiians, not-
23 withstanding any other provision of Federal or State
24 law, it shall be lawful for the private educational or-
25 ganization identified in section 7202(16) of the Ele-

1 mentary and Secondary Education Act of 1965 (20
2 U.S.C. 7512(16)) to continue to offer its educational
3 programs and services to Native Hawaiians (as de-
4 fined in section 7207 of that Act (20 U.S.C. 7517))
5 first and to others only after the need for such pro-
6 grams and services by Native Hawaiians has been
7 met.”.

8 (2) EFFECTIVE DATE.—The amendment made
9 by paragraph (1) takes effect on December 5, 2006.

10 (c) DEFINITION OF HEALTH PROMOTION.—Section
11 12(2) of the Native Hawaiian Health Care Act of 1988
12 (42 U.S.C. 11711(2)) is amended—

13 (1) in subparagraph (F), by striking “and” at
14 the end;

15 (2) in subparagraph (G), by striking the period
16 at the end and inserting “, and”; and

17 (3) by adding at the end the following:

18 “(H) educational programs with the mis-
19 sion of improving the health, capability, and
20 well-being of Native Hawaiians.”.