ending September 30, 2001, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mr. MCCONNELL:

S. 2522. An original bill making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2001, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mr. CONRAD (for himself and Mr. MURKOWSKI):

S. 2523. A bill to amen title XVIII of the Social Security Act to provide for reimbursement of certified midwife services, to provide for more equitable reimbursement rates for certified nurse-midwife services, and for other purposes; to the Committee on Finance.

By Ms. SNOWE:

S. 2524. A bill to amend title XVIII of the Social Security Act to expand coverage of bone mass measurements under part B of the Medicare Program to all individuals at clinical risk for osteoporosis; to the Committee on Finance.

By Mrs. FEINSTEIN (for herself, Mr. LAUTENBERG, Mrs. BOXER, and Mr. SCHUMER):

S. 2525. A bill to provide for the implementation of a system of licensing for purchasers of certain firearms and for a record of sale system for those firearms, and for other purposes; to the Committee on the Judiciary.

By Mr. CAMPBELL (for himself and Mr. INOUYE):

S. 2526. A bill to amend the Indian Health Care Improvement Act to revise and extend such Act; to the Committee on Indian Affairs.

By Mr. GRASSLEY:

S. 2527. A bill to amend the Public Health Service Act to provide grant programs to reduce substance abuse, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. BIDEN:

S. Res. 304. A resolution expressing the sense of the Senate regarding the development of educational programs on veterans' contributions to the country and the designation of the week that includes Veterans Day as ''National Veterans Awareness Week'' for the presentation of such educational programs; to the Committee on the Judiciary.

By Mr. NICKLES (for himself, Mr. KYL, Mr. LIEBERMAN, Mr. GRAHAM, Mr. GRASSLEY, and Mr. LUGAR):

S. Con. Res. 111. A concurrent resolution expressing the sense of the Congress regarding ensuring a competitive North American market for softwood lumber; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. VOINOVICH (for himself, Mr. REID, Mr. DEWINE, Mr. KENNEDY, Mr. BRYAN, Mr. MCCONNELL, Mr. HARKIN, Mr. THOMPSON. Mr. FRIST, and Mr. BUNNING):

S. 2519. A bill to authorize compensation and other benefits for employees of the Department of Energy, its contractors, subcontractors, and certain vendors who sustain illness or death related to exposure to beryllium, ionizing radiation, silica, or hazardous substances in the performance of their duties, and for other purposes; to the Committee on Health, Education, Labor, and Pension.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION ACT OF 2000

Mr. VOINOVICH. Mr. President, over the last half century, and at facilities all across America, tens of thousands of dedicated men and women in our civilian federal workforce helped keep our military fully supplied and our nation fully prepared to meet any potential threat. Their success is measured in part with the end of the Cold War and the collapse of the Soviet Union. However, for many of these workers, their success came at a high price; the sacrifice of their health, and even their lives, for our liberty. I believe we have a federal obligation to live up to our responsibilities with these Cold War veterans.

The bill I am introducing today, along with Senators REID, DEWINE, KENNEDY, MCCONNELL, BRYAN, HARKIN, THOMPSON, FRIST, and BUNNING is titled the ''Energy Employees Occupational Illness Compensation Act of 2000.'' This bill will provide financial compensation to Department of Energy workers whose impaired health has been caused by exposure to beryllium, radiation or other hazardous substances while working for the defense of the United States. The bill will also provide compensation to survivors of workers who have died while suffering from an illness resulting from exposure to these substances.

Many will express concern that it will be hard to prove if someone was made chronically ill by their work environment, however, such concerns can be refuted. For example, beryllium disease is a ''fingerprint'' disease, in that it leaves no doubt as to what caused the illness of the sufferer. Additionally, the only processing of the materials that cause Chronic Beryllium Disease is unique to our nuclear weapons facilities. Skepticism is understandable in many cases of radiation exposure at DoE facilities because the records may not generally reflect employee exposure to radioactive materials. However, concerns have been raised that the DoE destroyed or altered workers' records. Additionally, dosimeter badges, which record radiation exposure, were not always required to be worn by workers. When they were required to be worn, they were not always done so properly or consistently. DoE plant management would even ''zero'' dose badges. Therefore, many records do not exist, and where they do exist, there is adequate reason to doubt their accuracy. That is why this bill places the burden of proof on the government to prove that an employee's illness was not caused by workplace hazards.

As one who believes we should rely on sound science, I would certainly support a method for compensation based on this principle if it was available. Unfortunately in this case, sound science either does not exist in DoE facility records, or it cannot be relied upon for accuracy. That's precisely what happened in my state of Ohio.

In a series of newspaper articles from the Columbus Dispatch, it was shown that for decades, some workers at the Portsmouth Gaseous Diffusion Plant in Piketon, Ohio—a plant which processes high-quality nuclear material—did not know they had been exposed to dangerous levels of radioactive material. That's because until recently, proper safety precautions were rarely taken to adequately protect workers' safety. Even when precautions were taken, the application of protective standards was inconsistent. In addition, workers at the Piketon plant have stated that plant management not only did not keep adequate dosimetry records, in some cases, they changed the dosimetry records to show lower levels of radiation exposure. If consistent, reliable and factual data is not available, then it will be quite difficult to utilize sound science.

Similar occurrences have been reported at the Fernald Feed Materials Production Center in Fernald, Ohio and the Mound Facility in Miamisburg, Ohio as well as other facilities nationwide.

The DoE has admitted that at some facilities, workers were not told the nature of the substances with which they were working, nor the ramifications that these materials may have on their future health and quality of life. It is unconscionable that DoE managers and other individuals in positions of responsibility could be so insensitive and uncaring about their fellow man.

Last year, the Toledo Blade published an award-winning series of articles outlining the plight of workers suffering from Chronic Beryllium Disease (CBD). While government standards were met in protecting the workers from exposure to the beryllium dust, many workers still were diagnosed with CBD. The stories of these workers who are suffering from this often debilitating disease are heartwrenching. It is estimated that 1,200 people have contracted CBD, and hundreds have died from it, making CBD the number one disease directly caused by our Cold War effort.

Title one of this bill provides compensation to individuals suffering from Chronic Beryllium Disease (CBD). Beryllium, which is a toxic substance, can cause major health problems if proper precautions are not taken while it is being handled. Individuals who suffer from Chronic Beryllium Disease experience a loss of lung function, and in many cases face a painful death. While there is a blood test that can detect CBD, and there are treatments for it, there is no cure. Under this bill, if the disease is confirmed, it is presumed work-related and workers compensation at benefit levels established under

the Federal Employees Compensation Act (FECA) is paid—roughly two-thirds of six years worth of wages and health care coverage. Alternatively, a claimant can elect a one-time lump sum payment of $200,000 (with healthcare benefits related to their disease) in lieu of wage replacement payments. Employees at DoE sites and DoE beryllium vendors would be covered under the bill.

Title two of this bill covers illnesses related to radiation and other hazardous substances. The first part of this title covers workers at all DoE sites who contract cancer that has been potentially caused by exposure to radiation (radiogenic cancer), worked at the site for at least one year and wore a radiation dosimeter badge or should have worn one. Causation is presumed if the covered cancer is a primary cancer. Again, benefits are paid at FECA levels, or in the alternative, a claimant can elect a one-time lump sum payment of $200,000 (with healthcare benefits) in lieu of wage replacement payments. The presumption is modeled after the Radiation Exposure Compensation Act. This proposal incorporates all DoE sites across the nation, plus four vendor facilities.

The second part of this title covers workers at DoE sites for illness, impairment, disease or death, using a FECA level of benefits. The Secretary of Health and Human Services is required to create a panel of occupational doctors to review the claims for the Department of Labor, and the threshold for eligibility is whether exposure was a significant contributing factor to a worker's illness. The bill allows claimants to seek a second medical opinion. Further, the bill directs the HHS to empanel occupational physicians to develop additional presumptions for use in guiding future HHS and Labor Department decisions.

To obtain restitution under the bill, claimants would file with the Department of Labor's Office of Worker Compensation Programs under a FECA-like program but not FECA itself. The claims reviewer, after obtaining all the necessary information, would have 120 days to render a decision. If a denial is issued, the claimant can appeal to an administrative law judge (ALJ). The ALJ has 180 days to render an opinion. If an opinion is not rendered, the appeal can be brought to the federal Benefits Review Board (BRB). The BRB has 240 days to render an opinion, after which appeals can be brought to the U.S. Court of Appeals. Failure to meet deadlines by the DoL results in a default in favor of the claimant. This approach is intended to remedy the major defects in FECA, which excludes any rights to the Courts and results in years of delay in many cases.

Mr. President, there may be some who will say that this bill costs too much, or we can't afford it so we shouldn't do it. I strongly disagree.

Congress appropriates billions of dollars annually on things that are not the responsibility of the federal government. And here we have a clear instance where our federal government is responsible for the actions it has taken and the negligence it has shown against its own people. This is an issue where peoples' health has been compromised and lives have been lost. In many instances, these workers didn't even know that their health and safety was in jeopardy. It is not only a responsibility of this government to provide for these individuals, it is a moral obligation.

Mr. President, it is unfortunate that a bill establishing this type of compensation program is necessary; it is little consolation for the pain, health problems and diminished quality of life that these individuals have suffered. These men and women who won the Cold War have only asked that the United States government—the government of the nation that they spent their lives defending—acknowledge that they were made ill in the course of doing their job and recognize that the government must take care of them.

Sadly, because of the government's stonewalling and denial of responsibility, the only way many of these employees believe they will ever receive proper restitution for what the government has done is to file a lawsuit against the Department of Energy or its contractors. That should not have to happen and it is my hope that this legislation will preclude any perceived need for such lawsuits.

I believe that all those who have served our nation fighting the Cold War deserve to know if the federal government was responsible for causing them illness or harm, and if so, to provide them the care that they need. I encourage my colleagues to join us in cosponsoring this legislation and I urge the Senate to consider this bill during this session of Congress.

By Mr. JEFFORDS (for himself, Mr. WELLSTONE, Ms. SNOWE, and Ms. COLLINS):

S. 2520. A bill to amend the Federal Food, Drug, and Cosmetic Act to allow for the importation of certain covered products, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

MEDICINE EQUITY AND DRUG SAFETY ACT OF 2000

Mr. JEFFORDS. Mr. President, as we work to address the problems of health care in the new millennium, we are blessed and we are cursed: blessed with the promise of new research capabilities and the knowledge gleaned from the human genome, and cursed with the high costs of all medicines, new and old. Today, I come to the floor to introduce a bill that will help address the curse of out-of-control drug prices, the Medicine Equity and Drug Safety Act of 2000, or MEDS Act.

There is no question that prescription drugs cost too much in this nation.

During a time when we are experiencing unprecedented economic growth, it is not uncommon to hear of patients who cut pills in half, or skip dosages in order to make prescriptions last longer, because they can't afford the refill. The question that we should ask is, can we put politics aside and work in a bipartisan manner to deal with this national crisis? I say we must. And I am hopeful we can.

Prescription medicines have revolutionized the treatment of certain diseases, but they are only effective if patients have access to the medicines that their doctors prescribe.

The best medicines in the world will not help a person who cannot afford them. And they can actually do more harm than good if taken with the improper dosage.

Mr. President, it is well documented that the average price of prescription medicines is much lower in Canada than in the United States, with the price of some drugs in Vermont being twice that of the same drug available only a few miles away in a Canadian pharmacy. This is true even though many of the drugs sold in Canada are actually manufactured, packed, and distributed by American companies that sell the same FDA-approved products in both markets, but at drastically different prices.

This pricing disparity unfairly places the heaviest burden on the most vulnerable Americans—hardworking, but uninsured Americans who make too much money to qualify for Medicaid, yet still cannot afford the high cost of lifesaving drugs.

The legislation I am introducing today will allow pharmacists and wholesalers to get the same FDA-approved drugs sold at lower prices in other countries, and pass the savings on to consumers in the U.S.

This bipartisan proposal builds on legislation I introduced last year, S. 1462, that would allow imports from Canada for personal use, and borrows from another bill cosponsored by Senator WELLSTONE, S. 1191, that would allow reimportation of prescription drugs that were made in U.S. facilities.

The most important aspect of this bill, Mr. President, is safety. We all want to find ways to bring drug costs down for all Americans, but the concept of reimportation has been criticized as compromising the Food and Drug Administration's (FDA) world-renowned gold standard for safety by opening the American market to foreign counterfeiters who will attempt to flood the market with fake drugs.

This bill is simple in its approach. It would empower pharmacists and wholesalers to purchase FDA-approved medicines in Canada and pass the discounts along to American patients, and would let the experts at Health and Human Services (HHS) determine the best mechanism for allowing such imports while preserving the gold standard for safety.

The discretionary authority granted to the Secretary of HHS would be subject to a few important requirements,

such as identification of the importer and the product, but would require the Secretary to promulgate regulations setting up a safe system for allowing the reimportation of prescription drugs as long as the importer has demonstrated, to the satisfaction of HHS, that the product being reimported is safe, and is the same product that is being sold in the United States at a higher price.

Mr. President, I have said before and I will say again, this is not the only solution, and it may not be the best solution to this problem.

I strongly believe we need to enact a broad prescription drug benefit, and I believe we need to find ways to encourage more insurance coverage for more Americans that covers the cost of drugs. But this is a positive, bipartisan measure that we can implement now that will bring prescription drug prices down for all Americans, and I encourage your support.

Mr. WELLSTONE. Mr. President, I am very pleased to join Senator JEFFORDS, Senator COLLINS, and Senator SNOWE as a cosponsor of the Medicine Equity and Drug Safety Act of 2000. As this bill demonstrates, concern about the high price of prescription drugs in this country is a bipartisan issue. Republicans, Democrats, and independents alike suffer from the unconscionable behavior of American drug companies who overcharge American consumers day in and day out, compared to prices they charge in every other country of the world. Americans regardless of party have a fundamental belief in fairness—and know a rip-off when they see one. This bill aims to end the rip-off, to end the choke hold that the pharmaceutical industry has on America's seniors.

The Jeffords-Wellstone Medicine Equity and Drug Safety Act will make prescription drugs affordable for millions of Americans by applying the principles of free trade and competition to the prescription drug industry—without sacrificing safety. Senator JEFFORDS, Senator SNOWE, Senator COLLINS and I have heard the first-hand stories from our constituents—in Minnesota, in Maine and in Vermont—constituents who are justifiably frustrated and discouraged when they can't afford to buy prescription drugs that are made in the United States—unless they go across the border to Canada where those same drugs, manufactured in the same facilities here in the U.S. are available for about half the price.

This legislation provides relief from the price gouging of American consumers by our own pharmaceutical industry. This price gouging affects all Americans, but especially our senior citizens who feel the brunt of this problem more than any other age group because of the increasing number of prescription drugs we all will take as the years pass. Senior citizens have lost their patience in waiting for answers—-and so have I. That is why I have joined Senator JEFFORDS in this bipartisan effort to allow all Americans to have access to prescription drugs at prices they can afford.

While we can be proud of both American scientific research that produces new miracle cures and the high standards of safety and efficacy that we expect to be followed at the FDA, it is shameful that America's most vulnerable citizens—the chronically ill and the elderly—are being asked to pay the highest prices in the world here in the U.S. for the exact same medications manufactured here but sold more cheaply overseas.

Pharmacists could sell prescription drugs for less here in the United States, if they could buy and import these same drugs from Canada or Europe. Now, however, Federal law allows only the manufacturer of a drug to import it into the U.S. Thus American pharmacists and wholesalers must pay the exorbitant prices charged by the pharmaceutical industry in the U.S. market and pass along those high prices to consumers.

The legislative solution is simple. The bipartisan Medicine Equity and Drug Safety Act does two things: first, it allows Americans to legally import prescription drugs for personal use (which currently is allowed by FDA discretion), and more importantly, in the long run, it allows American pharmacists and wholesalers to import FDA approved prescription drugs into the United States for resale. Only drugs which have already been approved by the FDA for use in the United States could be imported for resale. Thus, the existing strict safety standards of the FDA will be maintained.

Pharmacists and wholesalers will be able to purchase drugs at lower prices and then pass the savings along to American consumers. To assure safety, the bill requires the FDA to develop regulations to precisely track imported drugs and to issue any other safety requirements the FDA deems necessary. It is time to tell the pharmaceutical industry: Enough! It is an industry that controls competition to keep prices so high that prescription drugs become unaffordable for the average American. It is an industry that puts profits first and leaves patients to fend for themselves.

What this bill does is to address the absurd situation by which American consumers are paying substantially higher prices for their prescription drugs than are the citizens of Canada, Mexico, and other countries. This bill does not create any new federal programs. Instead it uses principles of free trade and competition to help make it possible for American consumers to purchase the prescription drugs they need.

In summary, this bill brings competition into the price of pharmaceuticals and extends the promise of America's medical and pharmaceutical research to every American. It deserves bipartisan support, and I am glad to say it has it.

Ms. SNOWE. Mr. President, I am pleased to join Senators JEFFORDS, WELLSTONE, and COLLINS today as an original cosponsor of the Medicine Equity and Drug Safety Act of 2000.

There is no doubt that providing access to affordable prescription drugs for American consumers is a very important policy issue. It seems that everywhere we turn—from ''60 Minutes'' to Newsweek—we are hearing stories that our nation's patients face dramatically higher prices for their prescription medication than do our neighbors to the North.

In my view, a solution to the pressing problem of prescription drug coverage can't come soon enough. In 1998, drug costs grew more than any other category of health care—skyrocketing by 15.4 percent in a single year. And that's a special burden for seniors, who pay half the cost associated with their prescriptions as opposed to those under 65 who pay just a third.

Seniors are reeling from the burden of their prescription drug expenses. The March/April 2000 edition of Health Affairs reports that the average senior now spends $1,100 every year on medications. And with the latest HCFA estimates putting the number of seniors without drug coverage at around 31 percent of all Medicare beneficiaries—or about 13 out of nearly 40 million Americans—it's not hard to see why we can no longer wait to provide a solution. In fact, nearly 86 percent of Medicare beneficiaries must use at least one prescription drug every day.

Who are these seniors who don't have prescription drug coverage? Who are the ones traveling by the busload to Canada to buy their prescription drugs? They are people caught in the middle—most of whom are neither wealthy enough to afford their own coverage nor poor enough to qualify for Medicaid. In fact, we know that seniors between 100 percent and 200 percent of the federal poverty have the lowest levels of prescription drug coverage. And these seniors who are just over the poverty level are the least likely to have access to either employer-based coverage or Medicaid.

But even Medicaid is not the answer. According to the Urban Institute, in 1996, 63 percent of beneficiaries eligible for QMB (Qualified Medicare Beneficiary) protections—that is, those under the federal poverty level—actually receive those protections, while only 10 percent of those between 100 and 120 percent of the poverty level—those eligible for SLMB (Specified Low-Income Medicare Beneficiary) protections—are receiving that coverage. And only 16 states—including my home state of Maine—have their own drug assistance programs.

The high cost of prescription medications in the United States is forcing many of our nation's seniors to make unthinkable decisions that are harmful to their health and well-being. It is simply unacceptable that any person should have to choose between filling a prescription or buying groceries.

It is fundamentally unfair that a senior in Maine, Vermont, or Minnesota must drive across the Canadian border to be able to afford to buy his or her prescription medications. And while it is illegal for Americans to go to Canada and purchase drugs to be brought back to the United States, we know that this happens on a daily basis.

Mr. President, we are in a time of unparalleled prosperity. Almost daily, it seems, we learn of astounding new breakthroughs in biomedical research and in new prescription medications. And there is no question in anyone's mind that we have the best—the very best—health care in the entire world. But yet what does it say when our seniors are forced to go to Canada to purchase their prescription medications?

Mr. President, the legislation introduced today by Senator JEFFORDS will allow Americans to legally purchase in Canada a limited amount of their medication for personal use. This will enable American patients to purchase their medications at the lower prices. In addition, pharmacists and wholesalers will be allowed to reimport prescription drugs that were made in the U.S. or in FDA-approved facilities.

Mr. President, I support this bill and believe that Senator JEFFORDS has written a sound piece of legislation. But the fact of the matter is that addressing the issue of seniors crossing the border to purchase drugs is really only an interim approach—the real issue for America's seniors is the lack of comprehensive prescription drug coverage for Medicare beneficiaries.

This is why last August I introduced the Seniors Prescription Insurance Coverage Equity (SPICE) Act, S. 1480, with Senator RON WYDEN of Oregon. Our plan will give seniors coverage options similar to those enjoyed by Members of Congress and other federal employees, through a choice of competing comprehensive drug plans. SPICE will prescribe prescription drug coverage for all Medicare-eligible seniors, with the federal government covering all or part of the premiums on a sliding scale.

SPICE has the advantage of working with or without Medicare reform—something I've heard time and again is important to seniors, because it means that they don't have to wait for meaningful prescription drug coverage. The SPICE gives us the best of all possible worlds—a system that can exist outside of Medicare reform, co-exist with a new Medicare regime when it comes, and actually serve as a downpayment on comprehensive reform.

Mr. President, I am pleased to join Senator JEFFORDS as an original cosponsor of this bill. He has written a bill with the needs of American consumers in mind, and he is ensuring that Americans will have access to safe and affordable prescription medications while Congress works to devise a long-term solution to this very serious problem.

Thank you, I yield the floor.

By Ms. SNOWE:

S. 2524. A bill to amend title XVIII of the Social Security Act to expand coverage of bone mass measurements under part B of the Medicare Program to all individuals at clinical risk for osteoporosis; to the Committee on Finance.

MEDICARE OSTEOPOROSIS MEASUREMENT ACT OF 2000

● Ms. SNOWE. Mr. President, I rise today to introduce the Medicare Osteoporosis Measurement Act.

Three years ago Congress passed the Balanced Budget Act of 1997. In doing so, we dramatically expanded coverage of osteoporosis screening through bone mass measurements for Medicare beneficiaries. Since we passed this law, we have learned that under the current Medicare law, it is very difficult for a man to be reimbursed for a bone mass measurement test. The bill I am introducing today, the Medicare Osteoporosis Measurement Act, would help all individuals enrolled in Medicare to receive the necessary tests if they are at risk for osteoporosis.

Currently, Medicare guidelines allow for testing in five categories of individuals—and most ''at risk'' men do not fall into any of them. The first category in the guidelines is for ''an estrogen-deficient woman at clinical risk for osteoporosis.'' The bill I am introducing today changes this guideline to say that ''an individual, including an estrogen-deficient woman, at clinical risk for osteoporosis'' will be eligible for bone mass measurement. This change—of just a few words—will vastly increase the opportunities for men to be covered for the important test.

Osteoporosis is a major public health problem affecting 28 million Americans, who either have the disease or are at risk due to low bone mass. Today, two million American men have osteoporosis, and another three million are at risk of this disease. Osteoporosis causes 1.5 million fractures annually at a cost of $13.8 billion—$38 million per day—in direct medical expenses. In their lifetime, one in two women and one in eight men over the age of 50 will fracture a bone due to osteoporosis. Each year, men suffer one-third of all the hip fractures that occur, and one-third of these men will not survive more than a year. In addition to hip fracture, men also experience painful and debilitating fractures of the spine, wrist, and other bones due to osteoporosis.

Osteoporosis is largely preventable and thousands of fractures could be avoided if low bone mass were detected early and treated. Though we now have drugs that promise to reduce fractures by 50 percent and new drugs have been proven to actually rebuild bone mass, a bone mass measurement is needed to diagnose osteoporosis and determine one's risk for future fractures. And we have learned that there are some prominent risk facts: age, gender, race, a family history of bone fractures, early menopause, risky health behaviors such as smoking and excessive alcohol consumption, and some medications all have been identified as contributing factors to bone loss. But identification of risk factors alone cannot predict how much bone a person has and how strong bone is.

Mr. President, we know that osteoporosis is highly preventable, but only if it is discovered in time. There is simply no substitute for early detection. My legislation will ensure that all Medicare beneficiaries at risk for osteoporosis will be able to be tested for osteoporosis.●

By Mrs. FEINSTEIN (for herself, Mr. LAUTENBERG, Mrs. BOXER, and Mr. SCHUMER):

S. 2525. A bill to provide for the implementation of a system of licensing for purchasers of certain firearms and for a record of sale system for those firearms, and for other purposes; to the Committee on the Judiciary.

FIREARM LICENSING AND RECORD OF SALE ACT OF 2000

● Mrs. FEINSTEIN. Mr. President, on any given day in the United States 80 people are killed by gun violence, 12 of them children. Seeking to bring an end to this senseless violence, supporters of sensible gun laws are coming together this Mothers' Day from all over the country to participate in the Million Mom March and say to Congress: ''Enough is Enough.''

We share a common purpose: The passage of sensible gun laws that will hopefully help save lives.

This common goal includes moving forward with the four, common-sense gun measures passed by this body almost a full year ago—trigger locks, closing the gun show loophole, banning the importation of large capacity ammunition magazines, and banning juvenile possession of assault weapons.

And beyond those four common sense measures, the mothers flooding into Washington are calling for legislation to license gun owners and keep track of guns.

Earlier today, I stood with some of those moms, with Donna Dees-Thomases, the head of the Million Mom March, with Chief Ramsey of the District of Columbia Police Department, with representatives of Handgun Control and the Coalition to Stop Gun Violence, and with several of my colleagues to announce the introduction of a bill to take the next step in the fight to keep guns out of the hands of criminals and juveniles.

And so I now rise to introduce the ''Firearm Licensing and Record of Sale Act of 2000,'' which I believe represents a common-sense approach to guns and gun violence in America.

I am pleased to be joined in this effort by Senators FRANK LAUTENBERG, BARBARA BOXER and CHARLES SCHUMER. And I am pleased that Representative MARTY MEEHAN from Massachusetts will soon be introducing this legislation in the House. I know that this will be an uphill battle, and I don't expect this bill to pass overnight. But it is my

hope that in the coming months, more of our colleagues in both Houses will join us and help us to move this bill forward until we succeed.

Mr. President, in this country, when you want to hunt, you get a hunting license; when you want to fish, you get a fishing license. But when you want to buy a gun, no license is necessary. That makes no sense.

We register cars and license drivers. We register pesticides and license exterminators. We register animal carriers and researchers, we register gambling devices. And we register a whole host of other goods and activities—even ''international expositions,'' believe it or not, must be registered with the Bureau of International Expositions!

But when it comes to guns and gun owners—no license and no registration, despite the loss of more than 32,000 lives a year from gun violence.

To this end, I have worked with law enforcement officials and other experts in drafting the bill we are introducing today.

Upon enactment of this legislation, anyone purchasing a handgun or semi-automatic weapon that takes detachable ammunition magazines will be required to have a license. Shotguns and a large number of common hunting guns are not covered by the requirements of this bill.

Current owners of these weapons will have up to 10 years to obtain a license.

The bill sets up a federal system, but allows states to opt out if they adopt a system at least as effective as the federal program.

Under this bill, anyone wishing to obtain a firearm license will need to go to a federally licensed firearms dealer. There are currently more than 100,000 such dealers across the country—to put that in some perspective, there are four times more gun dealers in America than there are McDonald's restaurants in the entire world. Operating the federal licensing system through these licensed dealers will minimize the burden on those wishing to obtain a license.

If a state opts-out of the federal program, an individual will go to a State-designated entity, like a local sheriff, local police department, or even Department of Motor Vehicles. It will all depend on where the state feels is best.

Either way, the purchaser will then need to:

Provide information as to date and place of birth and name and address;

Submit a thumb print;

Submit a current photograph;

Sign, under penalty of perjury, that all of the submitted information is true and that the applicant is qualified under federal law to possess a firearm;

Pass a written firearms safety test, requiring knowledge of the safe storage and handling of firearms, the legal responsibilities of firearm ownership, and other factors as determined by the state or federal authority;

Sign a pledge to keep any firearm safely stored and out of the hands of juveniles (this pledge will be backed up by criminal penalties of up to three years in jail for anyone failing to do so);

Undergo state and federal background checks.

Licenses will be renewable every five years, and can be revoked at any time if the licensee becomes disqualified under federal law from owning or possessing a gun.

And the fee for a license cannot exceed $25.

Once the bill takes effect, all future sales and transfers of firearms falling within the scope of the bill will have to be recorded through a federally licensed firearms dealer, with an accompanying NICS background check. That way, law enforcement agencies will have easier access to information leading to the arrest of persons who use guns in crime.

The bill covers both handguns and other guns that are semi-automatic and can accept detachable magazines.

The legislation covers handguns because statistically, these guns are used in more crimes than any other. In fact, approximately 85 percent of all firearm homicides involve a handgun.

And the legislation also covers semi-automatic firearms that can accept detachable magazines, because these are the kind of assault weapons that have the potential to destroy the largest number of lives in the shortest period of time.

A gun that can take a detachable magazine can also take a large capacity magazine. Combine that with semi-automatic, rapid fire, and you have a deadly combination—as we have seen time and again in recent years.

Put simply, this legislation will cover those firearms that represent the greatest threat to the safety of innocent men, women and children in this nation.

Common hunting rifles, shotguns and other firearms that cannot accept detachable magazines will remain exempt.

This represents a compromise between those who would rather not have this bill at all, and those of us who believe that universal coverage of all firearms would be appropriate.

Penalties will vary depending on the severity of the violation. But in no case will gun owners face jail time simply because they forgot to get a license:

Those who fail to get a license will face fines of between $500 (for a first offense) and $5,000 for subsequent offenses.

Failing to report a change of address or the loss of a firearm will also result in penalties between $500 and $5,000, because this system works best for law enforcement when the perpetrators of gun crime can be quickly traced and arrested;

Dealers who fail to maintain adequate records will face up to 2 years in prison—dealers know their responsibilities, and this will give law enforcement the tools necessary to root out bad dealers and prevent the straw purchases and other violations of law that allow criminals easy access to a continuing flow of guns;

And adults who recklessly or knowingly allow a child access to a firearm face up to three years in prison if the child uses the gun to kill or seriously injure another person. In this way, the bill truly puts a new sense of responsibility onto gun owners in America.

Mr. President, law enforcement in California tells me that a licensing and record of sale system like the one I am introducing today will help law enforcement, upon recovery of a firearm used in crime, to track the gun down to the person who sold it, and then to the person who bought it.

And this legislation also sets in place a method through which we can better attempt to ensure that gun owners are responsible and trained in the use and care of their dangerous possessions.

We have tried to minimize the burden of this bill at every turn:

The licensing process will take place through federally licensed firearms dealers—as I mentioned earlier, there are currently more than 100,000 in this country;

The fee for a license will be only $25;

Current gun owners will have ten years to get a license, and guns now in homes will not have to be registered.

Future gun transfers will simply be recorded by licensed dealers—as they are now—and a system will be put in place to allow the quick tracing of guns used in crime. Gun owners themselves will not have to register their old guns or send any paperwork to the government.

Mr. President, this nation is awash in guns—there are more than 200 million of them in the United States. The problem of gun violence is not going away, and accidental deaths from firearms rob us of countless innocents each year.

Too many lives are lost every year simply because gun owners do not know how to use or store their firearms—particularly around children. In fact, according to a study released early last year, in 1996 alone there were more than 1,100 unintentional shooting deaths and more than 18,000 firearm suicides—many of which might have been prevented if the person intent on suicide did not have easy access to a gun owned by somebody else. It is my hope that the provisions of this bill, particularly with regard to child access prevention, will begin the process of making it harder for children and others to gain easy access to firearms.

I know that this bill will not pass overnight. We have a long process of education ahead of us. But the American people are with us. The facts are with us. And common sense is with us.

I thank the Senate for its consideration of this measure, and I look forward to working with each of my colleagues to move this bill forward in the coming months.●

By Mr. CAMPBELL (for himself and Mr. INOUYE):

S. 2526. A bill to amend the Indian Health Care Improvement Act to revise and extend such Act; to the Committee on Indian Affairs.

INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION OF 2000

Mr. CAMPBELL. Mr. President, I am pleased to be joined by Senator INOUYE today in introducing a bill to reauthorize the Indian Health Care Improvement Act (the ''IHCIA'' or the ''Act'').

The United States first began to provide health services to Indians in 1824 as part of the War Department's handling of Indian affairs. In 1849 this responsibility went to the newly-created Interior Department where it rested until 1955 when it was transferred to the Public Health Service's Indian Health Agency.

In 1970, President Nixon issued his now-famous ''Special Message to Congress on Indian Affairs'' laying out the rationale for a more enlightened Indian Policy—Indian Self Determination.

The Indian Self-Determination and Education Assistance Act of 1975, the Indian Health Care Improvement Act of 1976, and the amendments to each over the years can be traced directly to the fundamental change proposed in 1970.

I am happy to say that legislation I proposed earlier this session, the Indian Self Governance Amendments of 1999, have passed the House and the Senate and awaits final action.

With the introduction of this bill, we re-affirm the core principles that were part of the 1976 legislation: (1) that federal health services are consistent with the unique federal-tribal relationship; (2) that a goal of the U.S. is to provide the quantity and quality of services to raise the health status of Indians; and (3) that Indian participation in the planning and management of health services should be maximized.

First enacted in 1976, this IHCIA provides the authorization for programs run by the Indian Health Service and is the legislation most responsible for raising the health status of Indian people to a level that, while still alarming, is not nearly as serious as it was just twenty-five years ago.

Before the passage of the Act in 1976 the mortality rate for Indian infants was 25% higher than that of non-Indian babies. The death rates for mothers was 82% higher and the mortality rates from infectious disease caused diarrhea and dehydration was 138% greater.

Today we can see marked improvements. Infant mortality rates have been reduced by 54%, maternal mortality rates have been reduced by 65%, tuberculosis mortality by 80% and overall mortality rates have been reduced by 42%.

While encouraging, these statistics mask the fact that the health status of Native people in America is still poor and below that of all other groups.

There are 3 issues in particular that need to be raised: urban Indians; Indian health facilities construction needs; and the booming problem of diabetes.

As past censuses have shown, the 2000 decennial census is likely to show that more than one-half of the 2.3 million American Indians and Alaska Natives reside off-reservation and are what commonly called ''urban Indians.'' Though the health services framework that now exists has slowly begun to acknowledge this trend, I am concerned that urban Indian health care needs require a more focused approach.

An ongoing problem that continues to confront the tribes, the IHS, and the Congress is the growing backlog in health care facilities construction. Recent estimates show that these needs top $900 million and federal appropriations simply will not satisfy these needs. I strongly believe that innovative proposals need to be made, refined and perfected in order to accomplish our common goal. I am heartened by the success of the Joint Venture Program and want to explore other proposals to get these facilities built.

Ailments of affluence continue to seep into native communities and erode the quality of life and very social fabric that holds these communities together. Alcohol and substance abuse continue to take a heavy toll and diabetes rates are reaching alarmingly high rates. Most troubling is the increasing obesity and diabetes that is showing up with alarming frequency in Native youngsters.

It is now time to take that extra step an to look at the positive things we have accomplished and build upon them.

This bill is a step in the right direction. It is the product of months-long consultations by a group of very dedicated individuals consisting of Indian tribal leaders, legal professionals and representatives of the private and public health care sectors.

The group reviewed existing law and has proposed changes to improve the current system by stressing local flexibility and choice, and making it more responsive to the health needs of Indian people.

The Committee on Indian Affairs has already had one hearing on the bill and will continue to review it in the months ahead.

I ask unanimous consent that a copy of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 2526

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Indian Health Care Improvement Act Reauthorization of 2000''.

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

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

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

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

''SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

''(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

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

"SEC. 2. FINDINGS.

''Congress makes the following findings:

''(1) Federal delivery of health services and funding of tribal and urban Indian health

programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the Constitution, treaties, Federal laws, and the course of dealings of the United States with Indian Tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

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

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

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

''(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than that of the general population, and to provide for the maximum participation of Indian Tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

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

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

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

''SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

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

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

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

''(3) in order to raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto, to permit Indian Tribes and tribal organizations to set their own health care priorities and establish goals that reflect their unmet needs;

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

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

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

''SEC. 4. DEFINITIONS.

''In this Act:

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

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

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

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

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

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

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

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

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

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

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

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

''(13) RESERVATION.—The term 'reservation' means any Federally recognized Indian tribe's reservation, Pueblo or colony, including former reservations in Oklahoma, Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act, and Indian allotments.

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

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

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

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

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

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

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

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

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

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

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

''(A) regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940;

''(B) is an Eskimo or Aleut or other Alaskan Native;

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

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

''(23) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the participation of all interested Indian groups and individuals, and which is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

''TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

''SEC. 101. PURPOSE.

''The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to

the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health services to Indian people.

"SEC. 102. GENERAL REQUIREMENTS.

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

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

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

''(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations to prioritize the utilization of funds provided under this title within the service area.

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

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

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

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

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

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

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

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

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

''(b) ADMINISTRATIVE PROVISIONS.—

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

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

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

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

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

''(1) irrespective of whether such individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940;

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

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

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

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

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

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

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

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

''(1) Compensatory preprofessional education of any recipient. Such scholarship shall not exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act).

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

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

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

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

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

"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

''(a) SCHOLARSHIPS.—

''(1) IN GENERAL.—In order to meet the needs of Indians, Indian tribes, tribal organizations, and urban Indian organizations for health professionals, the Secretary, acting through the Service and in accordance with this section, shall provide scholarships through the area offices to Indians who are enrolled full or part time in accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall, except as provided in subsection (b), be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l).

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

''(b) ELIGIBILITY.—

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

''(2) SERVICE OBLIGATION.—

''(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year for year obligation, by service—

''(i) in the Indian Health Service;

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

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

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

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

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

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

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

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

''(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in

subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(3) PART TIME ENROLLMENT.—In the case of an Indian receiving a scholarship under this section who is enrolled part time in an approved course of study—

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

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

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

''(ii) two years; and

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

''(4) BREACH OF CONTRACT.—

''(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with the area office pursuant to a scholarship under this section and who—

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

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

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

''(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract;

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to him or her, or on his or her behalf, under the contract.

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

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

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

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

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

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

''(E) HARDSHIP OR GOOD CAUSE.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

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

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

''(1) PROVISION OF FUNDS.—

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

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

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

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—An Indian Tribe or tribal organization receiving funds under paragraph (1) shall agree to provide scholarships to Indians in accordance with the requirements of this subsection.

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

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

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

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

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

''(A) obligate such recipient to provide service in an Indian health program (as defined in section 110(a)(2)(A)) in the same service area where the Indian Tribe or tribal organization providing the scholarship is located, for—

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

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

''(B) provide that the scholarship—

''(i) may only be expended for—

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

''(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B), such amount to be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

''(ii) may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i);

''(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

''(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to the health profession involved.

''(5) BREACH OF CONTRACT.—

''(A) IN GENERAL.—An individual who has entered into a written contract with the Secretary and an Indian Tribe or tribal organization under this subsection and who—

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

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

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

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

shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract.

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

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

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

''(A) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

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

of such Act to provide service to individuals entitled to medical assistance under the plan.

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

''SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

''(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds to at least 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various colleges and universities throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

''(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.—The Secretary shall provide funds under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115, the Quentin N. Burdick Indians into Health Program authorized under section 117, and existing university research and communications networks.

''(c) REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

''(d) ACTIVE DUTY OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

''(1) in the Indian Health Service;

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

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

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

''SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

''(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship.

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

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

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

''SEC. 108. CONTINUING EDUCATION ALLOWANCES.

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

''SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

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

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

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

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

''(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such Program;

''(2) in order to provide such training, develop and maintain a curriculum that—

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

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

''(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and maintain programs that meet the needs for such continuing education;

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

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

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

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

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (referred to in this Act as the 'Loan Repayment Program') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

''(2) DEFINITIONS.—In this section:

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

''(i) directly by the Service;

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

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

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

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

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

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

''(1)(A) be enrolled—

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

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

''(B) have—

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

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

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

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

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

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

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

''(c) FORMS.—

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

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

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

''(d) PRIORITY.—

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

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

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

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

''(A) Indians; and

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

''(e) CONTRACTS.—

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

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

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

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

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

''(1) an agreement under which—

''(A) subject to paragraph (3), the Secretary agrees—

''(i) to pay loans on behalf of the individual in accordance with the provisions of this section; and

''(ii) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a tribe, tribal organization, or urban Indian organization as provided in subparagraph (B)(iii); and

''(B) subject to paragraph (3), the individual agrees—

''(i) to accept loan payments on behalf of the individual;

''(ii) in the case of an individual described in subsection (b)(1)—

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

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

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

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

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

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

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

''(g) LOAN REPAYMENTS.—

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

''(A) tuition expenses;

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

''(C) reasonable living expenses as determined by the Secretary.

''(2) AMOUNT OF PAYMENT.—

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

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

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

''(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

''(B) TIME FOR PAYMENT.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made not later than the end of the fiscal year in which the individual completes such year of service.

''(3) SCHEDULE FOR PAYMENTS.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

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

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

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

''(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian health programs pursuant to contracts entered into under this section, shall—

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

''(2) give priority to assigning individuals to Indian health programs that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

''(l) BREACH OF CONTRACT.—

''(1) IN GENERAL.—An individual who has entered into a written contract with the Secretary under this section and who—

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

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

''(ii) voluntarily terminates such enrollment; or

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

''(B) is enrolled in a graduate training program, and who fails to complete such training program, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii),

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

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

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

in which—

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

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

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

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

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

''(3) DAMAGES.—

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

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

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

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

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

''(m) CANCELLATION, WAIVER OR RELEASE.—

''(1) CANCELLATION.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

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

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

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

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

''(1) the health professional positions maintained by the Service or by tribal or Indian organizations for which recruitment or retention is difficult;

''(2) the number of Loan Repayment Program applications filed with respect to each type of health profession;

''(3) the number of contracts described in subsection (f) that are entered into with respect to each health profession;

''(4) the amount of loan payments made under this section, in total and by health profession;

''(5) the number of scholarship grants that are provided under section 105 with respect to each health profession;

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

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

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

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

''(a) ESTABLISHMENT.—Notwithstanding section 102, there is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

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

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

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

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

Amounts appropriated to the LRRF shall remain available until expended.

''(b) USE OF LRRF.—

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

''(A) to which a scholarship recipient under section 105 or a loan repayment program participant under section 110 has been assigned to meet the obligated service requirements pursuant to sections; and

''(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 105 or section 110.

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

''(c) INVESTING OF FUND.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE PRICE.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

"SEC. 112. RECRUITMENT ACTIVITIES.

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

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

"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

''(a) FUNDING OF PROJECTS.—The Secretary, acting through the Service, shall fund innovative projects for a period not to exceed 3 years to enable Indian tribes, tribal organizations, and urban Indian organizations to recruit, place, and retain health professionals to meet the staffing needs of Indian health programs (as defined in section 110(a)(2)(A)).

''(b) ELIGIBILITY.—Any Indian tribe, tribal organization, or urban Indian organization may submit an application for funding of a project pursuant to this section.

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

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

''(b) SERVICE OBLIGATION.—

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

''(2) FAILURE TO COMPLETE SERVICE.—In the event that an individual fails to complete a period of obligated service under paragraph (1), the individual shall be liable to the United States for the period of service remaining. In such event, with respect to individuals entering the project after the date of the enactment of this Act, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

''(c) OPPORTUNITY TO PARTICIPATE.—Health professionals from Indian tribes, tribal organizations, and urban Indian organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to participate in the program under subsection (a).

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

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

''(1) public or private schools of nursing;

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

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

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

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

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

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

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

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

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

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

''(d) PREFERENCES.—In providing funds under subsection (a), the Secretary shall extend a preference to—

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

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

''(3) programs that are interdisciplinary; and

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

''(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available to establish and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

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

''(1) in the Indian Health Service;

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

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

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

''SEC. 116. TRIBAL CULTURE AND HISTORY.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian tribes in each service area receive educational instruction in the history and culture of such tribes and their relationship to the Service.

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

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

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

''(3) include instruction in Native American studies.

''SEC. 117. INMED PROGRAM.

''(a) GRANTS.—The Secretary may provide grants to 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruitment program known as the 'Indians into Medicine Program' (referred to in this section as 'INMED') as a means of encouraging Indians to enter the health professions.

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

''(c) REQUIREMENTS.—

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

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

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

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

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

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

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

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

''(a) ESTABLISHMENT GRANTS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health profession for individuals who desire to practice such profession on an Indian reservation, in the Service, or in a tribal health program.

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

''(b) CONTINUATION GRANTS.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

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

''(A) is accredited;

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

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

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

''(ii) stipulate certifications necessary to approve internship and field placement opportunities at health programs of the Service or at tribal health programs;

''(D) has a qualified staff which has the appropriate certifications;

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

''(F) agrees to provide for Indian preference for applicants for programs under this section.

''(c) SERVICE PERSONNEL AND TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

''(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs, and

''(2) providing technical assistance and support to such colleges.

''(d) SPECIFIED COURSES OF STUDY.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

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

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

Such courses of study may be offered in conjunction with the college or university with which the community college has entered

into the agreement required under subsection (b)(2)(C).

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

''(f) DEFINITIONS.—In this section:

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

''(A) a tribally controlled community college; or

''(B) a junior or community college.

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

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

''SEC. 119. RETENTION BONUS.

''(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

''(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

''(2) the Secretary determines is needed by the Service, tribe, tribal organization, or urban organization;

''(3) has—

''(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban organization; or

''(B) completed any service obligations incurred as a requirement of—

''(i) any Federal scholarship program; or

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

''(4) enters into an agreement with the Service, Indian tribe, tribal organization, or urban Indian organization for continued employment for a period of not less than 1 year.

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

''(c) FAILURE TO COMPLETE TERM OF SERVICE.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(l)(2)(B).

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

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

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

''SEC. 120. NURSING RESIDENCY PROGRAM.

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

''(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) leading to an associate or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse) or an advanced degrees in nursing and public health.

''(c) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

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

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13; commonly known as the Snyder Act), the Secretary shall maintain a Community Health Aide Program in Alaska under which the Service—

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

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

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

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

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

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

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

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

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

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

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

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

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

''SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

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

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

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

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

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

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

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

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

''SEC. 124. SCHOLARSHIPS.

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

''SEC. 125. NATIONAL HEALTH SERVICE CORPS.

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

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

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

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

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

''(c) FULL TIME EQUIVALENT.—National Health Service Corps scholars that qualify for the commissioned corps in the Public Health Service shall be exempt from the full time equivalent limitations of the National

Health Service Corps and the Service when such scholars serve as commissioned corps officers in a health program operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization.

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

''(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

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

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

''(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

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

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

''(g) DEFINITIONS.—In this section:

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

''(A) Classroom education.

''(B) Clinical work experience.

''(C) Continuing education workshops.

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

''(3) TRIBALLY CONTROLLED POSTSECONDARY VOCATIONAL INSTITUTION.—The term 'tribally controlled postsecondary vocational institution' has the meaning given such term in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)).

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

''(a) STUDY AND LIST.—

''(1) IN GENERAL.—The Secretary and the Secretary of the Interior in consultation with Indian tribes and tribal organizations shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include or should include, training in the identification, prevention, education, referral or treatment of mental illness, dysfunctional or self-destructive behavior.

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

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

''(i) elementary and secondary education;

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

''(iii) law enforcement and judicial services; and

''(iv) alcohol and substance abuse;

''(B) staff positions within the Service; and

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

''(3) TRAINING CRITERIA.—

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

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

''(4) CULTURAL RELEVANCY.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

''(5) COMMUNITY EDUCATION.—

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

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

''(b) STAFFING.—

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

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

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

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

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

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

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

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

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

''(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

''(B) preventive health, including mammography and other cancer screening in accordance with section 207;

''(C) dental care;

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

''(E) emergency medical services;

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

''(G) accident prevention programs;

''(H) home health care;

''(I) community health representatives;

''(J) maintenance and repair; and

''(K) traditional health care practices.

''(b) USE OF FUNDS.—

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

''(2) ALLOCATION.—

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

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

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

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

''(A) the health status objective set forth in section 3(2) is not being achieved; and

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

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

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

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

''(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit to the Congress the current health status and resource deficiency report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

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

''(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service;

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

''(4) an estimate of—

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

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

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

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

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

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

''SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

''(a) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and through Indian tribes and tribal organizations, shall provide health promotion and disease prevention services to Indians so as to achieve the health status objective set forth in section 3(b).

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

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

''(A) controlling—

''(i) diabetes;

''(ii) high blood pressure;

''(iii) infectious agents;

''(iv) injuries;

''(v) occupational hazards and disabilities;

''(vi) sexually transmittable diseases; and

''(vii) toxic agents; and

''(B) providing—

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

''(ii) immunizations.

''(2) HEALTH PROMOTION.—The term 'health promotion' means fostering social, economic, environmental, and personal factors conducive to health, including—

''(A) raising people's awareness about health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information;

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

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

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

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

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

''(H) adequate and appropriate programs including—

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

''(iii) community health;

''(iv) community safety;

''(v) consumer health education;

''(vi) diet and nutrition;

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

''(viii) environmental health;

''(ix) exercise and physical fitness;

''(x) fetal alcohol disorders;

''(xi) first aid and CPR education;

''(xii) human growth and development;

''(xiii) injury prevention and personal safety;

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

''(xv) personal health and wellness practices;

''(xvi) personal capacity building;

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

''(xviii) psychological well being;

''(xix) reproductive health (family planning);

''(xx) safe and adequate water;

''(xxi) safe housing;

''(xxii) safe work environments;

''(xxiii) stress control;

''(xxiv) substance abuse;

''(xxv) sanitary facilities;

''(xxvi) tobacco use cessation and reduction;

''(xxvii) violence prevention; and

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

''(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement which is required to be submitted to Congress under section 801 an evaluation of—

''(1) the health promotion and disease prevention needs of Indians;

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

''(3) the internal capacity of the Service to meet such needs; and

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

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

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

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

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

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

''(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2012, each effective model diabetes project in existence on the date of the enactment of this Act and such other diabetes programs operated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.

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

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

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

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

''(3) ensure that data collected in each area office regarding diabetes and related complications among Indians is disseminated to tribes, tribal organizations, and all other area offices.

''SEC. 205. SHARED SERVICES.

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

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

''(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

''(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal facility be allocated proportionately between the Service and the tribe or tribal organization; and

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

''(c) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

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

''SEC. 206. HEALTH SERVICES RESEARCH.

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

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

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

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

''SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

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

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

''(2) Other cancer screening meeting national standards.

''SEC. 208. PATIENT TRAVEL COSTS.

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

''(1) Emergency air transportation and nonemergency air transportation where ground transportation is infeasible.

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

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

''SEC. 209. EPIDEMIOLOGY CENTERS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this Act, (including those centers for which funding is currently being provided through funding agreements under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in paragraph (2). Any centers established under the preceding sentence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

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

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

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

''(C) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

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

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

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

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

''(3) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

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

''SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

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

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

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

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

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

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

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

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

''(7) develop mental health wellness programs;

''(8) develop chronic disease prevention programs;

''(9) develop substance abuse prevention programs;

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

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

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

''(13) carry out violence prevention activities; and

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

''(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian tribes, tribal organization and urban Indian organizations in the development of comprehensive health education plans, and the dissemination of comprehensive health education materials and information on existing health programs and resources.

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

''(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

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

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

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

''(B) mental health wellness programs;

''(C) chronic disease prevention programs;

''(D) substance abuse prevention programs;

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

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

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

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

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

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

''SEC. 211. INDIAN YOUTH PROGRAM.

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

''(b) USE OF FUNDS.—

''(1) IN GENERAL.—Funds made available under this section may be used to—

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

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

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

''(c) REQUIREMENTS.—The Secretary shall—

''(1) disseminate to Indian tribes, tribal organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

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

''(3) at the request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance in the implementation of such models.

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

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

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

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

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

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

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

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

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

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

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

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

''(1) hospice care and assisted living;

''(2) long-term health care;

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

''(4) public health functions; and

''(5) traditional health care practices.

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

''(c) DEFINITIONS.—In this section:

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

''(A) Homemaker/home health aide services.

''(B) Chore services.

''(C) Personal care services.

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

''(E) Training for family members.

''(F) Adult day care.

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

''(2) HOSPICE CARE.—The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of such care.

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

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

''The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

''SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

''(a) STUDY AND MONITORING PROGRAMS.—The Secretary and the Service shall, in conjunction with other appropriate Federal agencies and in consultation with concerned

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

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

''(2) an analysis of the potential effect of ongoing and future environmental resource development on or near Indian reservations and communities including the cumulative effect of such development over time on health;

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

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

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

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

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

''(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

''(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

''(c) SUBMISSION TO CONGRESS.—

''(1) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Service shall submit to Congress a report concerning the study conducted under subsection (a).

''(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address the health problems involved.

''(d) TASK FORCE.—

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

''(A) The Secretary of Energy.

''(B) The Administrator of the Environmental Protection Agency.

''(C) The Director of the Bureau of Mines.

''(D) The Assistant Secretary for Occupational Safety and Health.

''(E) The Secretary of the Interior.

''(2) DUTIES.—The Task Force shall identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community, and enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

''(3) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

''(e) PROVISION OF APPROPRIATE MEDICAL CARE.—In the case of any Indian who—

''(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work related illness or condition;

''(2) is eligible to receive diagnosis and treatment services from a Service facility; and

''(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine or mill operator or entity responsible for the environmental hazard;

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

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

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

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

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

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

''(b) REIMBURSEMENT OF BOARD.—

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

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

''(3) LIMITATION.—No payment may be made for treatment provided under this section to the extent that payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

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

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

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

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

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

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

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

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

"SEC. 221.–LICENSING.

''Health care professionals employed by Indian Tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act,

shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

"SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES.

''With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

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

''(b) FAILURE TO RESPOND.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

''(c) PAYMENT.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

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

''(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services.

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

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

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

"TITLE III—FACILITIES

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

''(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

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

''(2) ensure, whenever practicable, that such facility meets the construction standards of any nationally recognized accrediting body by not later than 1 year after the date on which the construction or renovation of such facility is completed.

''(b) CLOSURE OF FACILITIES.—

''(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by the Service, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such proposed closure an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

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

''(B) the cost effectiveness of such closure;

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

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

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

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

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

''(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

''(c) PRIORITY SYSTEM.—

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

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

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

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

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

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

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

''(B) health care facility lists, including—

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

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

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

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

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

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

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

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

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

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

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

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

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

''(d) REVIEW OF NEED FOR FACILITIES.—

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

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

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

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

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

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

''(f) INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes, tribal organizations and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in

other sections of this title and other approaches.

"SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

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

''(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal facilities is primarily a health consideration and function;

''(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

''(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

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

''(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply facilities and sanitary sewage waste disposal facilities as soon as possible.

''(b) PROVISION OF FACILITIES AND SERVICES.—

''(1) IN GENERAL.—In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

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

''(A) financial and technical assistance to Indian tribes, tribal organizations and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the tribe or tribal organization;

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

''(C) priority funding for the operation, and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

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

''(A) the Secretary of Housing and Urban Development is authorized to transfer funds appropriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

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

''(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

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

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

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

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

''(H) the Secretary of Health and Human Services shall enter into inter-agency agreements with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the Department of Agriculture, the Environmental Protection Agency and other appropriate Federal agencies, for the purpose of providing financial assistance for safe water supply and sanitary sewage disposal facilities under this Act; and

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

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

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

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

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

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

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

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

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

''(h) REPORT.—

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

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

''(B) the methodology for determining sanitation deficiencies;

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

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

''(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any funding agreements entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe and in developing the criteria on which the needs will be evaluated through a process of negotiated rulemaking.

''(3) METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

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

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

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

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

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

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

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

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

''(C) A level III deficiency is an individual or community facility with water or sewer service in the home, piped services or a haul system with holding tanks and interior plumbing, or where major significant interruptions to water supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies. There is no access to or no approved or permitted solid waste facility available.

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

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

''(i) DEFINITIONS.—In this section:

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

''(2) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

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

''(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

''(1) ownership and control by Indians;

''(2) equipment;

''(3) bookkeeping and accounting procedures;

''(4) substantive knowledge of the project or function to be contracted for;

''(5) adequately trained personnel; or

''(6) other necessary components of contract performance.

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

''SEC. 304. SOBOBA SANITATION FACILITIES.

''Nothing in the Act of December 17, 1970 (84 Stat. 1465) shall be construed to preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat 674), as amended by the Act of July 31, 1959 (73 Stat. 267).

''SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

''(a) PERMISSIBILITY.—

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

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

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

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

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

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

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

''(1) the tribe or tribal organization—

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

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

''(2) the expansion renovation or modernization—

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

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

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

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

''(a) AVAILABILITY OF FUNDING.—

''(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to tribes and tribal organizations for the construction, expansion, or modernization of facilities for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided for in subsections (b)(2) and (c)(1)(C)). Funding under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

''(2) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian tribe or tribal organization) pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

''(b) USE OF FUNDS.—

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

''(A) located apart from a hospital;

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

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

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

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

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

''(2) LIMITATION.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion or modernization project that benefits the service population described in clauses (ii) and (iii) of paragraph (1)(C). The requirements of such clauses (ii) and (iii) shall not apply to a tribe or tribal organization applying for funding under this section whose principal office for health care administration is located on an island or where such office is not located on a road system providing direct access to an inpatient hospital where care is available to the service population.

''(c) APPLICATION AND PRIORITY.—

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

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

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

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

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

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

''(B) insufficient capacity to deliver such services.

''(d) FAILURE TO USE FACILITY AS HEALTH FACILITY.—If any facility (or portion thereof)

with respect to which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian tribe or tribal organization.

''(e) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Education Assistance Act or for reallocation or redesign thereunder.

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

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

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

''(1) waive any leasing prohibition;

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

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

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

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

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

''(c) CRITERIA.—

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

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

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

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

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

''(E) The project is economically viable.

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

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

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

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

''(A) Cass Lake, Minnesota.

''(B) Clinton, Oklahoma.

''(C) Harlem, Montana.

''(D) Mescalero, New Mexico.

''(E) Owyhee, Nevada.

''(F) Parker, Arizona.

''(G) Schurz, Nevada.

''(H) Winnebago, Nebraska.

''(I) Ft. Yuma, California

''(d) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

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

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

(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation and expansion needs of Service and non-Service facilities which are the subject of a funding agreement for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

''SEC. 308. LAND TRANSFER.

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

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

''SEC. 309. LEASES.

''(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes and tribal organizations for periods not in excess of 20 years. Property leased by the Secretary from an Indian tribe or tribal organization may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe or tribal organization.

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

''(1) title to;

''(2) a leasehold interest in; or

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

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

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

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

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

''(1) The principal amount of a loan or loan guarantee may cover up to 100 percent of eligible costs, including costs for the planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, other facility related costs and capital purchase (but excluding staffing).

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

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

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

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

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

''(7) In the planning and design of health facilities under this section, users eligible under section 807(b) may be included in any projection of patient population.

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

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

''(c) FUNDING.—

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

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

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

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

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the amount collected by the HCFLF during the preceding fiscal year, and all accrued interest on such amounts.

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

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

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

''(f) GRANTS.—The Secretary is authorized to establish a program to provide grants to Indian tribes and tribal organizations for the purpose of repaying all or part of any loan obtained by an Indian tribe or tribal organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

''SEC. 311. TRIBAL LEASING.

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

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

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian tribes and tribal organizations to establish joint venture demonstration projects under which an Indian tribe or tribal organization shall expend tribal, private, or other available funds, for the acquisition or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility.

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

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

''(b) REQUIREMENTS.—

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

''(A) the Secretary first determines that the Indian tribe or tribal organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in subsection (a)(1); and

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

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

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

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

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

''SEC. 313. LOCATION OF FACILITIES.

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

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

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

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

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

''SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

''(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

''(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

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

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

''(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

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

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

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

''(a) ESTABLISHMENT OF RENTAL RATES.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the Federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

''(2) OBJECTIVES.—In establishing rental rates under paragraph (1), an Indian tribe or tribal organization shall attempt to achieve the following objectives:

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

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

''(3) ELIGIBILITY FOR QUARTERS IMPROVEMENT AND REPAIR.—Any quarters whose rental rates are established by an Indian tribe or tribal organization under this subsection shall continue to be eligible for quarters improvement and repair funds to the same extent as other Federally-owned quarters that are used to house personnel in Service-supported programs.

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

''(b) COLLECTION OF RENTS.—

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

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

''(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

''(C) Such rent payments shall be retained by the Indian tribe or tribal organization and shall not be made payable to or otherwise be deposited with the United States.

''(D) Such rent payments shall be deposited into a separate account which shall be used by the Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

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

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

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

''(c) RATES.—To the extent that an Indian tribe or tribal organization, pursuant to authority granted in subsection (a), establishes rental rates for Federally-owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.–

''SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

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

''(b) FALSE OR MISLEADING LABELING.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made in America' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to the authorization contained in section 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

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

''SEC. 317. OTHER FUNDING FOR FACILITIES.

''Notwithstanding any other provision of law—

''(1) the Secretary may accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design and construct health care facilities for Indians and to place such funds into funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

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

''(3) any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency; and

''(4) the Secretary, acting through the Service, shall establish standards under regulations developed through rulemaking under section 802, for the planning, design and construction of health care facilities serving Indians under this Act.

''SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

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

''TITLE IV—ACCESS TO HEALTH SERVICES

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

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

''(b) EQUAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act in preference to an Indian beneficiary without such coverage.

''(c) SPECIAL FUND.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

''(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for benefits under title XVIII of the Social Security Act.

''SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM.

''(a) SPECIAL FUND.—

''(1) USE OF FUNDS.—Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such title. Any payments which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes. In making payments from such fund, the Secretary shall ensure that each service unit of the Service receives 100 percent of the amounts to which the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act.

''(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for medical assistance under title XIX of the Social Security Act.

''(b) PAYMENTS DISREGARDED FOR APPROPRIATIONS.—Any payments received under section 1911 of the Social Security Act for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

''(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405.

''SEC. 403. REPORT.

''(a) INCLUSION IN ANNUAL REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to the Congress under section 801, an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements under titles XVIII and XIX of the Social Security Act.

''(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian tribe or tribal organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an urban Indian organization receives funding from the Service under Title V of this Act and receives reimbursements or payments under title XVIII,

XIX, or XXI of the Social Security Act, such Indian tribe or tribal organization, or urban Indian organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

"SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and tribal organizations to assist such organizations in establishing and administering programs on or near Federal Indian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

''(1) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

''(2) pay premiums for health insurance coverage; and

''(3) apply for medical assistance provided pursuant to titles XIX and XXI of the Social Security Act.

''(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

''(1) determine the population of Indians to be served that are or could be recipients of benefits or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

''(2) assist individual Indians in becoming familiar with and utilizing such benefits and assistance;

''(3) provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits and assistance;

''(4) develop and implement—

''(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for health insurance coverage of needy individuals; and

''(B) methods of improving the participation of Indians in receiving the benefits and assistance provided under titles XVIII, XIX, and XXI of the Social Security Act.

''(c) AGREEMENTS FOR RECEIPT AND PROCESSING OF APPLICATIONS.—The Secretary may enter into an agreement with an Indian tribe or tribal organization, or an urban Indian organization, which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act and benefits under title XVIII of such Act by a Service facility or a health care program administered by such Indian tribe or tribal organization, or urban Indian organization, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act or a grant or contract entered into with an urban Indian organization under title V of this Act. Notwithstanding any other provision of law, such agreements shall provide for reimbursement of the cost of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may be included in an encounter rate or be made on a fee-for-service basis as appropriate for the provider. When necessary to carry out the terms of this section, the Secretary, acting through the Health Care Financing Administration or the Service, may enter into agreements with a State (or political subdivision thereof) to facilitate cooperation between the State and the Service, an Indian tribe or tribal organization, and an urban Indian organization.

''(d) GRANTS.—

''(1) IN GENERAL.—The Secretary shall make grants or enter into contracts with urban Indian organizations to assist such organizations in establishing and administering programs to assist individual urban Indians to—

''(A) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

''(B) pay premiums on behalf of such individuals for coverage under title XVIII of such Act; and

''(C) apply for medical assistance provided under title XIX of such Act and for child health assistance under title XXI of such Act.

''(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or entered into under paragraph (1) requirements that are—

''(A) consistent with the conditions imposed by the Secretary under subsection (b);

''(B) appropriate to urban Indian organizations and urban Indians; and

''(C) necessary to carry out the purposes of this section.

"SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

''(a) DIRECT BILLING.—

''(1) IN GENERAL.—An Indian tribe or tribal organization may directly bill for, and receive payment for, health care services provided by such tribe or organization for which payment is made under title XVIII of the Social Security Act, under a State plan for medical assistance approved under title XIX of such Act, under a State child health plan approved under title XXI of such Act, or from any other third party payor.

''(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act and section 2101(c) of such Act shall apply for purposes of reimbursement under the medicaid or State children's health insurance program for health care services directly billed under the program established under this section.

''(b) DIRECT REIMBURSEMENT.—

''(1) USE OF FUNDS.—Each Indian tribe or tribal organization exercising the option described in subsection (a) of this section shall be reimbursed directly under the medicare, medicaid, and State children's health insurance programs for services furnished, without regard to the provisions of sections 1880(c) of the Social Security Act and section 402(a) of this Act, but all funds so reimbursed shall first be used by the health program for the purpose of making any improvements in the facility or health programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such health services under the medicare, medicaid, or State children's health insurance program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used to provide additional health services, improvements in its health care facilities, or otherwise to achieve the health objectives provided for under section 3 of this Act.

''(2) AUDITS.—The amounts paid to the health programs exercising the option described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare, medicaid, and State children's health insurance programs.

''(3) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 401(c) or section 402(a), no payment may be made out of the special fund described in section 401(c) or 402(a), for the benefit of any health program exercising the option described in subsection (a) of this section during the period of such participation.

''(c) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under the medicaid or State children's health insurance program.

''(d) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

''(e) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

''(a) RIGHT OF RECOVERY.—Except as provided in subsection (g), the United States, an Indian tribe or tribal organization shall have the right to recover the reasonable charges billed or expenses incurred by the Secretary or an Indian tribe or tribal organization in providing health services, through the Service or an Indian tribe or tribal organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if—

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

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

''(b) URBAN INDIAN ORGANIZATIONS.—Except as provided in subsection (g), an urban Indian organization shall have the right to recover the reasonable charges billed or expenses incurred by the organization in providing health services to any individual to the same extent that such individual, or any other nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if such individual had been required to pay such charges or expenses and did pay such charges or expenses.

''(c) LIMITATIONS ON RECOVERIES FROM STATES.—Subsections (a) and (b) shall provide a right of recovery against any State,

only if the injury, illness, or disability for which health services were provided is covered under—

''(1) workers' compensation laws; or

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

''(d) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States or an Indian tribe or tribal organization under subsection (a), or an urban Indian organization under subsection (b).

''(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery provided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

''(f) METHODS OF ENFORCEMENT.—

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

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

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

''(ii) by any representative or heirs of such individual; or

''(B) instituting a civil action.

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

''(g) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

''(h) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded reasonable attorneys' fees and costs of litigation.

''(i) RIGHT OF ACTION AGAINST INSURERS AND EMPLOYEE BENEFIT PLANS.—

''(1) IN GENERAL.—Where an insurance company or employee benefit plan fails or refuses to pay the amount due under subsection (a) for services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the United States or an Indian tribe or tribal organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal, State or tribal law.

''(2) URBAN INDIAN ORGANIZATIONS.—Where an insurance company or employee benefit plan fails or refuses to pay the amounts due under subsection (b) for health services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the urban Indian organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal or State law.

''(j) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization, or an urban Indian organization shall have a right of recovery for any otherwise reimbursable claim filed on a current HCFA-1500 or UB-92 form, or the current NSF electronic format, or their successors. No health plan shall deny payment because a claim has not been submitted in a unique format that differs from such forms.

''SEC. 407. CREDITING OF REIMBURSEMENTS.

''(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87-693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

''(b) NO OFFSET OF FUNDS.—The Service may not offset or limit the amount of funds obligated to any service unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

''SEC. 408. PURCHASING HEALTH CARE COVERAGE.

''An Indian tribe or tribal organization, and an urban Indian organization may utilize funding from the Secretary under this Act to purchase managed care coverage for Service beneficiaries (including insurance to limit the financial risks of managed care entities) from—

''(1) a tribally owned and operated managed care plan;

''(2) a State or locally-authorized or licensed managed care plan; or

''(3) a health insurance provider.

''SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VETERAN'S AFFAIRS, AND OTHER FEDERAL AGENCY HEALTH FACILITIES AND SERVICES SHARING.

''(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

''(1) IN GENERAL.—The Secretary shall examine the feasibility of entering into arrangements or expanding existing arrangements for the sharing of medical facilities and services between the Service and the Veterans' Administration, and other appropriate Federal agencies, including those within the Department, and shall, in accordance with subsection (b), prepare a report on the feasibility of such arrangements.

''(2) SUBMISSION OF REPORT.—Not later than September 30, 2000, the Secretary shall submit the report required under paragraph (1) to Congress.

''(3) CONSULTATION REQUIRED.—The Secretary may not finalize any arrangement described in paragraph (1) without first consulting with the affected Indian tribes.

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

''(1) the priority access of any Indian to health care services provided through the Service;

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

''(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

''(4) the quality of health care services provided to any veteran by the Veteran's Administration;

''(5) the eligibility of any Indian to receive health services through the Service; or

''(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration provided, however, the Service or the Indian tribe or tribal organization shall be reimbursed by the Veterans' Administration where services are provided through the Service or Indian tribes or tribal organizations to beneficiaries eligible for services from the Veterans' Administration, notwithstanding any other provision of law.

''(c) AGREEMENTS FOR PARITY IN SERVICES.—The Service may enter into agreements with other Federal agencies to assist in achieving parity in services for Indians. Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Service.

''SEC. 410. PAYOR OF LAST RESORT.

''The Service, and programs operated by Indian tribes or tribal organizations, or urban Indian organizations shall be the payor of last resort for services provided to individuals eligible for services from the Service and such programs, notwithstanding any Federal, State or local law to the contrary, unless such law explicitly provides otherwise.

''SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH CARE PROGRAMS .

''Notwithstanding any other provision of law, the Service, Indian tribes or tribal organizations, and urban Indian organizations (notwithstanding limitations on who is eligible to receive services from such entities) shall be entitled to receive payment or reimbursement for services provided by such entities from any Federally funded health care program, unless there is an explicit prohibition on such payments in the applicable authorizing statute.

''SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

''(a) IN GENERAL.—Notwithstanding any other provision of law, including the Anti-Deficiency Act, provided the Indian tribes to be served approve, the Service in the Tuba City Service Unit may—

''(1) enter into a demonstration project with the State of Arizona under which the Service would provide certain specified medicaid services to individuals dually eligible for services from the Service and for medical assistance under title XIX of the Social Security Act in return for payment on a capitated basis from the State of Arizona; and

''(2) purchase insurance to limit the financial risks under the project.

''(b) EXTENSION OF PROJECT.—The demonstration project authorized under subsection (a) may be extended to other service units in Arizona, subject to the approval of the Indian tribes to be served in such service units, the Service, and the State of Arizona.

''SEC. 413. ACCESS TO FEDERAL INSURANCE.

''Notwithstanding the provisions of title 5, United States Code, Executive Order, or administrative regulation, an Indian tribe or

tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.

"SEC. 414. CONSULTATION AND RULEMAKING.

''(a) CONSULTATION.—Prior to the adoption of any policy or regulation by the Health Care Financing Administration, the Secretary shall require the Administrator of that Administration to—

''(1) identify the impact such policy or regulation may have on the Service, Indian tribes or tribal organizations, and urban Indian organizations;

''(2) provide to the Service, Indian tribes or tribal organizations, and urban Indian organizations the information described in paragraph (1);

''(3) engage in consultation, consistent with the requirements of Executive Order 13084 of May 14, 1998, with the Service, Indian tribes or tribal organizations, and urban Indian organizations prior to enacting any such policy or regulation.

''(b) RULEMAKING.—The Administrator of the Health Care Financing Administration shall participate in the negotiated rulemaking provided for under title VIII with regard to any regulations necessary to implement the provisions of this title that relate to the Social Security Act.

"SEC. 415. LIMITATIONS ON CHARGES.

''No provider of health services that is eligible to receive payments or reimbursements under titles XVIII, XIX, or XXI of the Social Security Act or from any Federally funded (whether in whole or part) health care program may seek to recover payment for services—

''(1) that are covered under and furnished to an individual eligible for the contract health services program operated by the Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization, in an amount in excess of the lowest amount paid by any other payor for comparable services; or

''(2) for examinations or other diagnostic procedures that are not medically necessary if such procedures have already been performed by the referring Indian health program and reported to the provider.

"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHORITY.

''Notwithstanding any other provision of law, the Secretary may not waive the application of section 1902(a)(13)(D) of the Social Security Act to any State plan under title XIX of the Social Security Act.

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

''Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

''(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

''(1) any Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act;

''(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

''(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2000); or

''(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of this Act (as so in effect), or other applicable law, to pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization;

provided the exchange arises from or relates to such health programs.

''(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES AND PREMIUMS.

''(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an Indian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

''(b) EXEMPTION FROM PREMIUMS.—

''(1) MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for medical assistance under title XIX of the Social Security Act or child health assistance under title XXI of such Act may be charged a premium as a condition of receiving such assistance under title XIX of XXI of such Act.

''(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian Tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

''For the purpose of determining the eligibility under section 1902(a)(10)(A)(ii)(IV) of the Social Security Act of an Indian for medical assistance under a State plan under title XIX of such Act, the cost of providing services to an Indian in a health program of the Service, an Indian Tribe or tribal organization, or an urban Indian organization shall be deemed to have been an expenditure for health care by the Indian.

"SEC. 421. ESTATE RECOVERY PROVISIONS.

''Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

''(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

''(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of Federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

''(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

''(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

"SEC. 422. MEDICAL CHILD SUPPORT.

''Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization. For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian Tribe or tribal organization or an urban Indian organization and another health provider.

"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

''(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian Tribe or tribal organization or an urban Indian organization shall have a right of recovery under section 408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian Tribe or tribal organization or an urban Indian organization.

''(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied

upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement may not be made a prerequisite for such payments to be made.

''(c) PARITY.—Payments due under subsection (a) from a managed care entity may not be paid at a rate that is less than the rate paid to a 'preferred provider' by the entity or, in the event there is no such rate, the usual and customary fee for equivalent services.

''(d) NO CLAIM REQUIREMENT.—A managed care entity may not deny payment under subsection (a) because an enrollee with the entity has not submitted a claim.

''(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

''(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

''(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under any managed care entity participating in a State plan under title XIX or XXI of the Social Security Act unless the Indian had the option of enrolling in a managed care plan or health program administered by the Service, an Indian tribe or tribal organization, or an urban Indian organization.

''(h) INDIAN MANAGED CARE PLANS.—Notwithstanding any other provision of law, any State entering into agreements with one or more managed care organizations to provide services under title XIX or XXI of the Social Security Act shall enter into such an agreement with the Service, an Indian tribe or tribal organization or an urban Indian organization under which such an entity may provide services to Indians who may be eligible or required to enroll with a managed care organization through enrollment in an Indian managed care organization that provides services similar to those offered by other managed care organizations in the State. The Secretary and the State are hereby authorized to waive requirements regarding discrimination, capitalization, and other matters that might otherwise prevent an Indian managed care organization or health program from meeting Federal or State standards applicable to such organizations, provided such Indian managed care organization or health program offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

''(i) ADVERTISING.—A managed care organization entering into a contract to provide services to Indians on or near an Indian reservation shall provide a certificate of coverage or similar type of document that is written in the Indian language of the majority of the Indian population residing on such reservation.

''SEC. 424. NAVAJO NATION MEDICAID AGENCY.

''(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary may treat the Navajo Nation as a State under title XIX of the Social Security Act for purposes of providing medical assistance to Indians living within the boundaries of the Navajo Nation.

''(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

''(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

''(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such Nation, include Western and traditional Navajo healing services) within the Navajo Nation. Such assistance may include providing funds for demonstration projects conducted with such Nation.

''(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per cent with respect to amounts the Navajo Nation Medicaid agency expends for medical assistance and related administrative costs.

''(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of Title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

''(g) SCHIP.—At the option of the Navajo Nation, the Secretary may treat the Navajo Nation as a State for purposes of title XXI of the Social Security Act under terms equivalent to those described in the preceding subsections of this section.

''SEC. 425. INDIAN ADVISORY COMMITTEES.

''(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

''(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

''SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title.''.

''TITLE V—HEALTH SERVICES FOR URBAN INDIANS

''SEC. 501. PURPOSE.

''The purpose of this title is to establish programs in urban centers to make health services more accessible and available to urban Indians.

''SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

''Under the authority of the Act of November 2, 1921 (25 U.S.C. 13)(commonly known as the Snyder Act), the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within urban centers, of programs which meet the requirements set forth in this title. The Secretary, through the Service, subject to section 506, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

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

''(a) AUTHORITY.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

''(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

''(2) estimate the current health status of urban Indians residing in such urban center or centers;

''(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

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

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

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

''(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under this section. Such criteria shall, among other factors, include—

''(1) the extent of unmet health care needs of urban Indians in the urban center or centers involved;

''(2) the size of the urban Indian population in the urban center or centers involved;

''(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

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

''(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

''(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center or centers; and

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

''(c) HEALTH PROMOTION AND DISEASE PREVENTION.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a).

''(d) IMMUNIZATION SERVICES.—

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

''(3) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

''(e) MENTAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

''(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

''(3) USE OF FUNDS.—Grants may be made under this subsection—

''(A) to prepare assessments required under paragraph (2);

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

''(C) to provide outpatient behavioral health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support groups, family treatment, and other treatment; and

''(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

''(f) CHILD ABUSE.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

''(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

''(3) USE OF FUNDS.—Grants may be made under this subsection—

''(A) to prepare assessments required under paragraph (2);

''(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

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

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

''(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

''(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

''(C) the assessment required under paragraph (2).

''(g) MULTIPLE URBAN CENTERS.—The Secretary, acting through the Service, may enter into a contract with, or make grants to, an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to urban Indians in more than one urban center.

''SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

''(a) AUTHORITY.—

''(1) IN GENERAL.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503.

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

''(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

''(1) the urban Indian organization successfully undertake to—

''(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

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

''(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

''(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

''SEC. 505. EVALUATIONS; RENEWALS.

''(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title and compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

''(b) COMPLIANCE WITH TERMS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian organization which has entered into a contract or received a grant under section 503 with the terms of such contract of grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

''(1) conduct, through the Service, an annual onsite evaluation of the organization; or

''(2) accept, in lieu of an onsite evaluation, evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the medicare program under Title XVIII of the Social Security Act.

''(c) NONCOMPLIANCE.—

''(1) IN GENERAL.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

''(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with such organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract or grant is not renewed under this section.

''(d) DETERMINATION OF RENEWAL.—In determining whether to renew a contract or grant with an urban Indian organization

under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

''(a) APPLICATION OF FEDERAL LAW.—Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

''(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

''(1) be made in their entirety by the Secretary to the urban Indian organization by not later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

''(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the expenditure of such funds.

''(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

''(d) FAIR AND UNIFORM PROVISION OF SERVICES.—Contracts with, or grants to, urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

''(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indians, as defined in section 4(f), shall be eligible for health care or referral services provided pursuant to this title.

"SEC. 507. REPORTS AND RECORDS.

''(a) REPORT.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into, or a grant received, pursuant to this title, such organization shall submit to the Secretary, on a basis no more frequent than every 6 months, a report including—

''(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

''(2) information on activities conducted by the organization pursuant to the contract or grant;

''(3) an accounting of the amounts and purposes for which Federal funds were expended; and

''(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary, after consultations consistent with section 514, with urban Indian organizations.

''(b) AUDITS.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

''(c) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

''(1) a certified public accountant; or

''(2) a certified public accounting firm qualified to conduct Federal compliance audits.

"SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

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

"SEC. 509. FACILITIES.

''(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

''(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

''(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

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

''(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility, or 25 years.

''(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the revenue of the organization as security for a loan or loan guarantee under this subsection.

''(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

''(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

''(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

''(A) such amounts as may be appropriated to the URLF;

''(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

''(C) interest earned on amounts in the URLF under paragraph (3).

''(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

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

"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

''There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

''(1) carrying out the provisions of this title;

''(2) providing central oversight of the programs and services authorized under this title; and

''(3) providing technical assistance to urban Indian organizations.

"SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES.

''(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom the Secretary has entered into a contract under this title or under section 201.

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

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

''(1) size of the urban Indian population;

''(2) capability of the organization to adequately perform the activities required under the grant;

''(3) satisfactory performance standards for the organization in meeting the goals set forth in such grant, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and

''(4) identification of need for services.

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

''(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

''(a) OKLAHOMA CITY CLINIC.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Oklahoma City Clinic demonstration project shall be treated as a service unit in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.

''(2) REPORT.—The Secretary shall submit to the President, for inclusion in the report

required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration project specified in paragraph (1).

''(b) TULSA CLINIC.—Notwithstanding any other provision of law, the Tulsa Clinic demonstration project shall become a permanent program within the Service's direct care program and continue to be treated as a service unit in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

''SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

''(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2001, with urban Indian organizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section to as 'NIAAA') and transferred to the Service.

''(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

''(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

''(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

''SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

''(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension and which emphasizes trust, respect, and shared responsibility.

''SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

''For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian organization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

''SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

''(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting.

''(b) STATES.—A State described in this subsection is a State in which—

''(1) there reside urban Indian youth with a need for alcohol and substance abuse treatment services in a residential setting; and

''(2) there is a significant shortage of culturally competent residential treatment services for urban Indian youth.

''SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

''(a) IN GENERAL.—The Secretary shall permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

''(b) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the General Services Administration for purposes of carrying out the contract or grant.

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

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

''(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

''SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

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

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

''(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

''(1) the size and location of the urban Indian population to be served;

''(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

''(3) performance standards for the urban Indian organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

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

''(5) the willingness of the urban Indian organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the area office of the Service in which the organization is located.

''(d) APPLICATION OF CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

''SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

''The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

''SEC. 520. REGULATIONS.

''(a) EFFECT OF TITLE.—This title shall be effective on the date of enactment of this Act regardless of whether the Secretary has promulgated regulations implementing this title.

''(b) PROMULGATION.—

''(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

''(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270 days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

''(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

''(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursuant to section 565 of Title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

''(d) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of this Act.

''SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

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

''TITLE VI—ORGANIZATIONAL IMPROVEMENTS

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

''(a) ESTABLISHMENT.—

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

''(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

''(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

''(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

''(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

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

''(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

''(A) this Act;

''(B) the Act of November 2, 1921 (25 U.S.C. 13);

''(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

''(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

''(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

''(4) all scholarship and loan functions carried out under title I.

''(d) AUTHORITY.—

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

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

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

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

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

''SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, shall establish an automated management information system for the Service.

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

''(A) a financial management system;

''(B) a patient care information system;

''(C) a privacy component that protects the privacy of patient information;

''(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service;

''(E) an interface mechanism for patient billing and accounts receivable system; and

''(F) a training component.

''(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

''(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

''(2) meet the management information needs of the Service.

''(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

''(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

''SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

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

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

''(a) PURPOSES.—It is the purpose of this section to—

''(1) authorize and direct the Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs;

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

''(3) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

''(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

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

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

''(b) BEHAVIORAL HEALTH PLANNING.—

''(1) AREA-WIDE PLANS.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for Indian Behavioral Health Services. The plans shall, to the extent feasible, include—

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

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

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

''(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

''(C) an estimate of the additional funding needed by the Service, Indian tribes, tribal organizations and urban Indian organizations to meet their responsibilities under the plans.

''(2) NATIONAL CLEARINGHOUSE.—The Secretary shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such plans and outcomes by any Indian tribe, tribal organization, urban Indian organization or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be utilized and adopted locally.

''(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

''(1) a comprehensive continuum of behavioral health care that provides for—

''(A) community based prevention, intervention, outpatient and behavioral health aftercare;

''(B) detoxification (social and medical);

''(C) acute hospitalization;

''(D) intensive outpatient or day treatment;

''(E) residential treatment;

''(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

''(G) emergency shelter;

''(H) intensive case management; and

''(I) traditional health care practices; and

''(2) behavioral health services for particular populations, including—

''(A) for persons from birth through age 17, child behavioral health services, that include—

''(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

''(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

''(iii) services for co-occurring disorders (multiple diagnosis);

''(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

''(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

''(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

''(vii) co-morbidity services;

''(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

''(i) early intervention, treatment and aftercare services;

''(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

''(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

''(iv) healthy choices and life style services (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

''(v) female specific treatment services for—

''(I) women at risk of giving birth to a child with a fetal alcohol disorder;

''(II) substance abuse requiring gender specific services;

''(III) sexual assault and domestic violence; and

''(IV) healthy choices and life style (parenting, partners, obesity, suicide and other related behavioral risk); and

''(vi) male specific treatment services for—

''(I) substance abuse requiring gender specific services;

''(II) sexual assault and domestic violence; and

''(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

''(C) family behavioral health services, including—

''(i) early intervention, treatment and aftercare for affected families;

''(ii) treatment for sexual assault and domestic violence; and

''(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

''(D) for persons age 56 years and older, elder behavioral health services including—

''(i) early intervention, treatment and aftercare services that include—

''(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

''(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

''(III) healthy choices and life style services (managing conditions related to aging);

''(ii) elder women specific services that include—

''(I) treatment for substance abuse requiring gender specific services and

''(II) treatment for sexual assault, domestic violence and neglect;

''(iii) elder men specific services that include—

''(I) treatment for substance abuse requiring gender specific services; and

''(II) treatment for sexual assault, domestic violence and neglect; and

''(iv) services for dementia regardless of cause.

''(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

''(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

''(2) TECHNICAL ASSISTANCE.—In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

''(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

''(e) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

''(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conversion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

''SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

''(a) IN GENERAL.—Not later than 1 year days after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

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

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

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

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

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

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

''(5) the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

''(6) a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

''(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diagnosed individuals requiring mental health and substance abuse treatment; and

''(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

''(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412); and

''(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

''(b) SPECIFIC PROVISIONS.—The memorandum of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

''(1) the determination of the scope of the problem of alcohol and substance abuse among Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

''(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

''(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

''(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

''(1) Indian tribes and tribal organizations;

''(2) Indian individuals;

''(3) urban Indian organizations and other Indian organizations;

''(4) behavioral health service providers.

''(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Federal Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

''SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including traditional health care practices, which shall include—

''(A) prevention, through educational intervention, in Indian communities;

''(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

''(C) community-based rehabilitation and aftercare;

''(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

''(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children.

''(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

''(b) CONTRACT HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

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

''SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

''(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

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

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

''(b) TRAINING.—In carrying out subsection (a)(1), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

''(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

''(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section involves the utilization and promotion of the traditional Indian health care and treatment practices of the Indian tribes to be served.–

''SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

''Subject to section 220, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

''(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling psychologist;

''(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

''(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

''SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

''(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

''(b) USE OF FUNDS.—Funding provided pursuant to this section may be used to—

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

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

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

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

''(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 707. INDIAN YOUTH PROGRAM.

''(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

''(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment center or treatment network in each area under the jurisdiction of an area office.

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

''(2) FUNDING.—For the purpose of staffing and operating centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

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

''(4) SPECIFIC PROVISION OF FUNDS.—

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

''(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska;

''(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l));

''(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

''(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treatment Center, a residential youth treatment facility in New Mexico.

''(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youth residing in such State.

''(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes and tribal

organizations, may provide intermediate behavioral health services, which may incorporate traditional health care practices, to Indian children and adolescents, including—

''(A) pre-treatment assistance;

''(B) inpatient, outpatient, and after-care services;

''(C) emergency care;

''(D) suicide prevention and crisis intervention; and

''(E) prevention and treatment of mental illness, and dysfunctional and –self-destructive behavior, including child abuse and family violence.

''(2) USE OF FUNDS.—Funds provided under this subsection may be used—

''(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

''(B) to hire behavioral health professionals;

''(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided; and

''(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

''(E) intensive home and community based services.

''(3) CRITERIA.—The Secretary shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

''(d) FEDERALLY OWNED STRUCTURES.—

''(1) IN GENERAL.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

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

''(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

''(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

''(e) REHABILITATION AND AFTERCARE SERVICES.—

''(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and implement within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

''(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

''(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

''(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youth residing in Indian communities, on Indian reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youth.

"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION AND STAFFING ASSESSMENT. —

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems.

''(b) TREATMENT OF CALIFORNIA.—For purposes of this section, California shall be considered to be 2 areas of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

''(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.–

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

''(a) COMMUNITY EDUCATION.—

''(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each service unit or tribal program a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community.

''(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

''(3) TRAINING.—Community-based training (oriented toward local capacity development) under a program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

''(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders, to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

''(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

''(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

''(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

''(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 710. BEHAVIORAL HEALTH PROGRAM.

''(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian Tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

''(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

''(1) Whether the project will address significant unmet behavioral health needs among Indians.

''(2) Whether the project will serve a significant number of Indians.

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

''(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

''(5) Whether the project will deliver services in a manner consistent with traditional health care.

''(6) Whether the project is coordinated with, and avoids duplication of, existing services.

''(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

''(a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the purposes of meeting the health status objective specified in section 3(b).

''(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

''(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

''(B) identify and provide behavioral health treatment to high-risk women;

''(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

''(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

''(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

''(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

''(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

''(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

''(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

''(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

''(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

''(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

''(c) TASK FORCE.—

''(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

''(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

''(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian Tribes, tribal organizations and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol disorders.

''(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

''SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

''(1) victims of child sexual abuse; and

''(2) perpetrators of child sexual abuse.

''(b) USE OF FUNDS.—Funds provided under this section shall be used to—

''(1) develop and provide community education and prevention programs related to child sexual abuse;

''(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

''(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

''(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

''(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated, and to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

''SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

''(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, tribal organizations and urban Indian organizations or, enter into contracts with, or make grants to appropriate institutions, for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

''(1) the inter-relationship and interdependance of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

''(2) the development of models of prevention techniques.

''(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

''SEC. 714. DEFINITIONS.

''In this title:

''(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis and dissemination of information on health status, health needs and health problems.

''(2) ALCOHOL RELATED NEURODEVELOPMENTAL DISORDERS.—The term 'alcohol related neurodevelopmental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

''(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

''(4) BEHAVIORAL HEALTH AFTERCARE.—

''(A) IN GENERAL.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse or mental health outpatient or outpatient treatment, to help prevent or treat relapse, including the development of an aftercare plan.

''(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

''(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.–

''(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

''(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be met:

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

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

''(C) Prenatal or postnatal growth delay.

''(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means a history of maternal alcohol consumption during pregnancy having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

''(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to engage in usual and customary life activities through education and therapy.–

''(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse. —

''SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

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

''TITLE VIII—MISCELLANEOUS

''SEC. 801. REPORTS.

''The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—

''(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population, including specific comparisons of appropriations provided and those required for such parity;

''(2) a report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the allocation of funding pursuant to section 808;

''(3) a report on the use of health services by Indians—

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

''(B) by gender and age;

''(C) by source of payment and type of service;

''(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

''(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

''(4) a report of contractors concerning health care educational loan repayments under section 110;

''(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

''(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

''(7) a report on infectious diseases as required under section 212;

''(8) a report on environmental and nuclear health hazards as required under section 214;

''(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

''(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

''(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

''(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

''(13) a report providing an accounting of reimbursement funds made available to the Secretary under titles XVIII and XIX of the Social Security Act as required under section 403(a);

''(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

''(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

''(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

''(17) a report on the evaluation of programs as required under section 513; and

''(18) a report on alcohol and substance abuse as required under section 701(f).

''SEC. 802. REGULATIONS.

''(a) INITIATION OF RULEMAKING PROCEDURES.—

''(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act.

''(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

''(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

''(b) RULEMAKING COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of Title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian tribes, and tribal organizations, a majority of whom shall be nominated by and be representatives of Indian tribes, tribal organizations, and urban Indian organizations from each service area.

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

''(d) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

''(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

''SEC. 803. PLAN OF IMPLEMENTATION.

''Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

''SEC. 804. AVAILABILITY OF FUNDS.

''Amounts appropriated under this Act shall remain available until expended.

''SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

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

''SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

''(a) ELIGIBILITY.—

''(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

''(1) Any member of a Federally recognized Indian tribe.

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

''(A) is a member of the Indian community served by a local program of the Service; and

''(B) is regarded as an Indian by the community in which such descendant lives.

''(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

''(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

''(b) RULE OF CONSTRUCTION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

''SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

''(a) INELIGIBLE PERSONS.—

''(1) IN GENERAL.—Any individual who—

''(A) has not attained 19 years of age;

''(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

''(C) is not otherwise eligible for the health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

''(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

''(b) PROGRAMS AND SERVICES.—

''(1) PROGRAMS.—

''(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other subsection of this section or under any other provision of law if—

''(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

''(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

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

''(II) there is no reasonable alternative health program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

''(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under such funding agreement is authorized to determine whether health services should be provided under such funding agreement to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

''(2) LIABILITY FOR PAYMENT.—

''(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security

Act, shall be credited to the account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

''(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent person.

''(3) SERVICE AREAS.—

''(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing body of the Indian tribe revokes its concurrence to the provision of such health services.

''(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

''(c) PURPOSE FOR PROVIDING SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

''(1) achieve stability in a medical emergency;

''(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

''(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or

''(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

''(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

''(e) DEFINITION.—In this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

"SEC. 808. REALLOCATION OF BASE RESOURCES.

''(a) REQUIREMENT OF REPORT.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a service unit may be implemented only after the Secretary has submitted to the President, for inclusion in the report required to be transmitted to the Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

''(b) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

"SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

''The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

"SEC. 810. PROVISION OF SERVICES IN MONTANA.

''(a) IN GENERAL.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr. 1987).

''(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

''During the period of the moratorium imposed by Public Law 100-446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

''For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, Chapter 372), an Indian tribe or tribal organization carrying out a funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

''For purposes of section 4 of Public Law 102-585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et. seq.) shall be deemed to be an executive agency and part of the Service in the and, as such, may act as an ordering agent of the Service and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

''(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

''(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

''(1) Ten members of Congress, of which—

''(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

''(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

''(C) two members shall be from the Senate and shall be appointed by the majority leader; and

''(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the provision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

''(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected by the Indian tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

''(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian Tribes.

''(c) TERMS.—

''(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

''(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

''(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

''(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

''(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

''(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian Tribes;

''(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

''(A) to the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian tribes, tribal organizations and urban Indian organizations, and which may include authorizing and funding feasibility studies of various models for providing and funding health services for all Indian beneficiaries including those who live outside of a reservation, temporarily or permanently;

''(B) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provide,d and the cost, including mechanisms for funding of the health services to be provided;

''(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

''(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

''(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each Federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

''(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

''(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

''(e) ADMINISTRATIVE PROVISIONS.—

''(1) COMPENSATION AND EXPENSES.—

''(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), while serving on the business of the Commission (including travel time) shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(2) MEETINGS AND QUORUM.—

''(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

''(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

''(3) DIRECTOR AND STAFF.—

''(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

''(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

''(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

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

''(f) POWERS.—

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

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

''(3) COST ESTIMATES.—

''(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

''(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

''(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any federal Agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the federal employee.

''(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal Agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

''(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal Agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(7) OBTAINING INFORMATION.—The Commission may secure directly from the any Federal Agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

''(8) SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

''(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

''SEC. 815. APPROPRIATIONS; AVAILABILITY.

''Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

''SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

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

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by adding a semicolon at the end;

(2) in subparagraph (S), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.''.

SEC. 202. INDIAN HEALTH PROGRAMS.

Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended to read as follows:

''INDIAN HEALTH PROGRAMS

''SEC. 1880. (a) ELIGIBILITY FOR PAYMENTS.—The Indian Health Service (referred to in this section as the 'Service') and an Indian tribe or tribal organization, or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization meets the

conditions and requirements for such payments which are applicable generally to the service or provider type for which the Service, Indian tribe or tribal organization, or urban Indian organization seeks payment under this title and for services and provider types provided by a qualified Indian health program under section 1880A.

''(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Service, an Indian tribe or tribal organization, or urban Indian organization, does not meet all of the conditions and requirements of this title which are applicable generally to the service or provider type for which payment is sought, but submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

''(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act.

''(d) COMMUNITY HEALTH AIDES.—The Service or an Indian Tribe or tribal organization providing a service otherwise eligible for payment under this section through the use of a community health aide or practitioner certified under the provisions of section 121 of the Indian Health Care Improvement Act shall be paid for such services on the same basis that such services are reimbursed under State plans approved under title XIX.

''(e) TREATMENT OF CERTAIN PROGRAMS.—Notwithstanding any other provision of law, a health program operated by the Service or an Indian tribe or tribal organization, which collaborates with a hospital operated by the Service or an Indian tribe or tribal organization, shall, at the option of the Indian tribe or tribal organization, be paid for services for which it would otherwise be eligible for under this as if the health program were an outpatient department of the hospital. In situations where the health program is on a separate campus from the hospital, billing as an outpatient department of the hospital shall not subject such a health program to the requirements of section 1867.

''(f) PAYMENT FOR CERTAIN NURSING SERVICES.—The Service or an Indian tribe or tribal organization providing visiting nurse services in a home health agency shortage area shall be paid for such services on the same basis that such services are reimbursed under this title for other primary care providers.

''(g) ALTERNATIVE METHODS OF REIMBURSEMENT.—Notwithstanding any other provision of law, the Secretary may identify and implement alternative methods of reimbursing Indian health programs for services reimbursable under this title that are provided to Indians, so long as such methods—

''(1) allow an Indian tribe or tribal organization or urban Indian organization to opt to receive reimbursement under reimbursement methodologies applicable to other providers of similar services; and

''(2) provide that the amount of reimbursement resulting under any such methodology shall not be less than 100 percent of the reasonable cost of the service to which the methodology applies under section 1861(v).''.

SEC. 203. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

''QUALIFIED INDIAN HEALTH PROGRAM

''SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

''(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by-

''(A) the Indian Health Service;

''(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; and

''(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

''(2) INCLUDED PROGRAMS AND ENTITIES.—Such term may include 1 or more hospital, nursing home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

''(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

''(c) DETERMINATION OF PAYMENTS.—

''(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

''(2) DEFINITION OF FULL COST RECOVERY.—

''(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

''(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into account the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

''(ii) indirect costs which, in the case of a qualified Indian health program—

''(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

''(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

''(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

''(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

''(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

''(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

''(B) NO SINGLE REPORT REQUIREMENT.—Not all health programs provided or administered by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

''(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report shall be made on a fee-for-service, encounter, or per diem basis.

''(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

''(A) a significant decreases in discharges;

''(B) costs for graduate medical education programs;

''(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

''(D) payment for outlier cases.

''(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

''(A) on the full cost recovery basis provided in paragraphs (1) through (5);

''(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

''(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

''(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian Tribe or tribal organization; or

''(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

''(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

''(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

''(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

''(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies

furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

''(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health setting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

''(C) preventive primary health services as described under sections 329, 330, and 340 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

''(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screening, diagnostic, and treatment services as described in section 1905(r);

''(E) influenza and pneumococccal immunizations;

''(F) other immunizations for prevention of communicable diseases when targeted; and

''(G) the cost of transportation for providers or patients necessary to facilitate access for patients.''.

Subtitle B—Medicaid

SEC. 211. PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.

Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by adding ''and'' at the end; and

(3) by adding at the end the following:

''(D)(i) for payment for services described in section 1905(a)(2)(C) under the plan furnished by an Indian tribe or tribal organization or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, the same methodology used under section 1833(a)(3), and

''(ii) in the case of such services furnished pursuant to a contract between the a Federally-qualified health center and a medicaid managed care organization under section 1903(m), for payment to the Federally-qualified health center at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract.''.

SEC. 212. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (65), by striking the period; and

(2) by inserting after (65), the following:

''(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

''(A) the term 'meaningful consultation' is defined through the negotiated rulemaking process provided for under section 802 of the Indian Health Care Improvement Act; and

''(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.''.

SEC. 213. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

''Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.''.

SEC. 214. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

''INDIAN HEALTH SERVICE PROGRAMS

''SEC. 1911. (a) IN GENERAL.—The Indian Health Service and an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as such Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable generally to the service for which it seeks reimbursement under this title and for services provided by a qualified Indian health program under section 1880A.

''(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

''(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations and urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking ''For purposes'' and inserting the following:

''(1) IN GENERAL.—Subject to paragraph (2), for purposes''; and

(2) by adding at the end the following:

''(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).''.

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting ''an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)'' after ''Service''.

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

''(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

''(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

''(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

''(2) under an agreement entered into under subsection (a) between the entity and the Secretary.''.

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101-630 (25 U.S.C. 1653 note) is repealed.

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

Mr. INOUYE. Mr. President, I rise today to join my Chairman, Senator BEN NIGHTHORSE CAMPBELL, in the introduction of a bill to reauthorize the Indian Health Care Improvement Act of 1976, Public Law 94–437.

Mr. President, for the past two years, the leaders of Indian country have been engaged in a consultation process with the Indian Health Service in an effort to address changes to the Act which would hold the potential of improving and enhancing the ability of tribal health programs, urban Indian health care programs, and the Indian Health Service to provide comprehensive primary health care and public health services to all eligible American Indian and Alaska Native patients citizens.

The goal of the consultation process was to build a consensus on the best means of addressing the health care challenges that confront Native America, so that the reauthorization bill could reflect a unified vision of the Indian Health Service, tribal governments and urban Indian health care programs. The tribal participants in this process appropriately named this comprehensive consultation process ''Speaking with One Voice''.

Mr. President, this tribally-developed reauthorization bill is the most comprehensive to date. The first step in the consultation process was the convening of a roundtable discussion with tribal leaders, urban Indian health care providers, Indian Health Service health care professionals, national Indian health organizations, researchers, and other policy makers. Specific recommendations regarding the manner in which tribal consultation meetings would be carried out were developed at this Roundtable. From these recommendations, the Roundtable participants developed a consultation approach that included the pursuit of consensus on what amendments to the Act were necessary and the identification of opportunities for change, the identification of area and regional differences, the promotion of a partnership environment for tribes, urban Indians, and the Indian Health Service, and the establishment of a core group to review materials.

Beginning in the fall of 1998, tribal representatives participated in twelve Area meetings to begin discussing concerns and recommendations related to the Act. Each of the twelve geographic Areas facilitated a consultation process with health care providers in their respective Areas, and this process was completed in January 1999.

Four regional consultation meetings were held across the country from January to April, 1999. Regional meetings were intended to provide a forum for tribes to provide input, to share the recommendations from each Area, and to build consensus among participants for a unified position from each regional meeting. From these four meetings, a matrix of 135 recommendations for each of the sections in the Indian Health Care Improvement Act was developed, as well as proposals for new provisions. Over 900 health care providers participated in the four regional meetings.

Upon the completion of the four regional meetings, the Indian Health Service convened a National Steering committee composed of elected tribal representatives and urban Indian health care program directors. Many of the members of the steering committee had participated in the Area and regional consultation meetings. The National Steering Committee developed a draft consensus bill based on the Area and regional consultation meetings. The draft bill was mailed to every tribal government and urban Indian health care program in the nation with a 30-day period for additional comments. The draft bill was then presented at a national meeting in Washington, D.C. in late July of last year. Participants in this national meeting included tribal government leaders, urban Indian health care providers, members of Congress and their staff, as well as several Administration and departmental officials.

The National Steering Committee has completed a monumental task with the broad support of Indian Tribes and communities across the United States.

With this in mind, I urge my colleagues to support this legislation.

By Mr. GRASSLEY:

S. 2527. A bill to amend the Public Health Service Act to provide grant programs to reduce substance abuse, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

DRUG TREATMENT AND RESEARCH ENHANCEMENT ACT

Mr. GRASSLEY. Mr. President, I am sending a bill to the desk to help reinforce our national drug control effort. I held a hearing earlier today on the domestic consequences of a new wave of heroin use. This is a flesh and blood problem that touches all of us. What we see in our homes and schools across the nation is the emergence of a new threat to our young people. A purer form of heroin is making its presence felt. In rich neighborhoods and poor. In our cities and rural areas. In the lives of our young people and their families.

No heroin consumed in this country is made here. Every gram of it is grown in some foreign field, processed in a distant, illegal lab, and smuggled into this country. Yet, this heroin makes its way here by every means possible. It walks, floats, flies, and sneaks across our borders.

While the heroin used here comes from overseas, the consequences of its coming are felt in our homes, in our schools, in our neighborhoods. It is our young people who die. It is American families who bear the burden and pay the price. Heroin is an equal opportunity destroyer. It blights inner city streets, suburban neighborhoods, and rural communities alike. I fear that the problem is getting worse. And I am concerned that our current policies are simply not up to the challenge.

Somewhere along the way, we lost the clear, consistent message that the only proper response to drugs is to say an emphatic ''NO''. We're supposed to be more sophisticated. More tolerant. More willing to listen to notions of making dangerous drugs more available. What all of this ''more'' has meant is that we have more young people using more drugs at younger ages. Today's heroin is cheaper and purer and more widely available. It is more aggressively marketed and it is presented as being safer, as ''user friendly''.

In the late 1980s and early 1990s, heroin had a bad rap. All drugs did. That is less true today. In the last several years, heroin use among young people has doubled and attitudes about the dangers of the drug have shifted. While it is true that most of our 12 to 20 year olds still believe it bad, the new heroin that we see on our streets and in our schools is marketed to avoid this stigma. The chief reason that the old heroin was seen as bad was because you needed a needle to use it. With the new heroin you can get high from smoking or inhaling, at least at first. And we now have well-moneyed think tank talking heads who preach that the only consequence of heroin addiction is a mild case of constipation. That it is our drug laws that are dangerous not the drugs. In such an environment, we should not be too surprised that an increasing number of young people should be persuaded that heroin is okay.

Communities in Plano, Texas and Orlando, Florida learned this to their dismay when dozens of high school kids died from heroin overdoses. I can think of no pain greater than that of a parent who must bid farewell forever to a child. It is somehow contrary to the natural order for a parent to precede a child in death. But the pain of addiction is a spreading circle of hurt. The hearing I held today on this problem brought this point home in the voices of those most affected: addicts and their families.

The legislation that I offer today will help us address this new problem before it gets any worse. I am proposing that we look at the means to improve our prevention message to stop drug use before it starts. I hope to revitalize community and parent involvement.

I am also proposing increased resources for addiction research and ways to get the best information and best practices into the hands of the professionals who must deal with addiction problems.

In addition, I am calling for a new initiative to support juvenile residential treatment programs that work. Current research shows that we need more focused, long-term critical intervention for young addicts to break the cycle of addiction today before it becomes a worse problem tomorrow. Investment now means better chances for young people and for all of us later.

It's not just a new heroin that plagues us. Designer drugs like methamphetamine and now Ecstasy are flooding this country. Along with heroin, these are marketed to our young people as safe and friendly. Left unanswered, we will see another generation of young lives blighted. We will see families torn up by a widening circle of hurt from drug use. We saw what a similar wave of drug use did to us and to a generaton of young people in the 1960s and 1970s. We cannot afford to go through this again. I hope we can begin today to renew our commitment to a drug free future for our young people. I ask my colleagues to join me in supporting the Drug Treatment and Research Enhancement Act.

ADDITIONAL COSPONSORS

S. 512

At the request of Mr. GORTON, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 512, a bill to amend the Public Health Service Act to provide for the expansion, intensification, and coodination of the activities of the Department of Health and Human Services with respect to research on autism.

S. 662

At the request of Mr. L. CHAFEE, the name of the Senator from Idaho (Mr. CRAPO), was added as a cosponsor of S. 662, a bill to amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program.

S. 882

At the request of Mr. MURKOWSKI, the names of the Senator from North Dakota (Mr. DORGAN) and the Senator from Montana (Mr. BURNS) were added as cosponsors of S. 882, a bill to strengthen provisions in the Energy Policy Act of 1992 and the Federal Nonnuclear Energy Research and Development Act of 1974 with respect to potential Climate Change.

S. 1333

At the request of Mr. WYDEN, the name of the Senator from Minnesota (Mr. GRAMS) were added as a cosponsor of S. 1333, a bill to expand homeownership in the United States.

S. 1464

At the request of Mr. HAGEL, the name of the Senator from Virginia (Mr. ROBB) was added as a cosponsor of S. 1464, a bill to amend the Federal Food, Drug, and Cosmetic Act to establish certain requirements regarding the Food Quality Protection Act of 1996, and for other purposes.

S. 1668

At the request of Mr. KERRY, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1668, a bill to amend title VII of the Civil Rights Act of 1964 to establish provisions with respect to religious accommodation in employment, and for other purposes.

S. 1874

At the request of Mr. GRAHAM, the names of the Senator from Pennsylvania (Mr. SPECTER) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of S. 1874, a bill to improve academic and social outcomes for youth and reduce both juvenile crime and the risk that youth will become victims of crime by providing productive activities conducted by law enforcement personnel during non-school hours.

S. 1989

At the request of Mr. KOHL, the name of the Senator from Wisconsin (Mr. FEINGOLD) was added as a cosponsor of S. 1989, a bill to ensure that employees of traveling sales crews are protected under the Fair Labor Standards Act of 1938 and under other provisions of law.

S. 2062

At the request of Mr. DEWINE, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 2062, a bill to amend chapter 4 of title 39, United States Code, to allow postal patrons to contribute to funding for organ and tissue donation awareness through the voluntary purchase of certain specially issued United States postage stamps.

S. 2069

At the request of Mr. ENZI, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of S. 2069, a bill to permit the conveyance of certain land in Powell, Wyoming.

S. 2107

At the request of Mr. GRAMM, the names of the Senator from Utah (Mr. BENNETT), the Senator from Indiana (Mr. BAYH), the Senator from New Jersey (Mr. TORRICELLI), and the Senator from Idaho (Mr. CRAPO) were added as cosponsors of S. 2107, a bill to amend the Securities Act of 1933 and the Securities Exchange Act of 1934 to reduce securities fees in excess of those required to fund the operations of the Securities and Exchange Commission, to adjust compensation provisions for employees of the Commission, and for other purposes.

S. 2217

At the request of Mr. CAMPBELL, the name of the Senator from Montana (Mr. BURNS), was added as a cosponsor of S. 2217, a bill to require the Secretary of the Treasury to mint coins in commemoration of the National Museum of the American Indian of the Smithsonian Institution, and for other purposes.

S. 2225

At the request of Mr. GRASSLEY, the name of the Senator from Rhode Island (Mr. L. CHAFEE) was added as a cosponsor of S. 2225, a bill to amend the Internal Revenue Code of 1986 to allow individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs.

S. 2287

At the request of Mr. L. CHAFEE, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 2287, a bill to amend the Public Health Service Act to authorize the Director of the National institute of Environmental Health Sciences to make grants for the development and operation of research centers regarding environmental factors that may be related to the etiology of breast cancer.

S. 2311

At the request of Mr. JEFFORDS, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 2311, supra.

At the request of Mr. KENNEDY, the name of the Senator from New York (Mr. MOYNIHAN) was added as a cosponsor of S. 2311, a bill to revise and extend the Ryan White CARE Act programs under title XXVI of the Public Health Service Act, to improve access to health care and the quality of health care under such programs, and to provide for the development of increased capacity to provide health care and related support services to individuals and families with HIV diseases, and for other purposes.

S. 2333

At the request of Mr. REED, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 2333, a bill to amend the Federal Food, Drug, and Cosmetic Act to grant the Food and Drug Administration the authority to regulate the manufacture, sale, and distribution of tobacco and other products containing nicotine, tar, additives, and other potentially harmful constituents, and for other purposes.

S. 2357

At the request of Mr. REID, the name of the Senator from South Dakota (Mr. DASCHLE) was added as a cosponsor of S. 2357, a bill to amend title 38, United States Code, to permit retired members of the Armed Forces who have a service-connected disability to receive military retired pay concurrently with veterans' disability compensation.

S. 2386

At the request of Mrs. FEINSTEIN, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 2386, a bill to extend the Stamp Out Breast Cancer Act.

S. 2393

At the request of Mr. DURBIN, the name of the Senator from Ohio (Mr. VOINOVICH) was added as a cosponsor of S. 2393, a bill to prohibit the use of racial and other discriminatory profiling in connection with searches and detentions of individuals by the United