Indian Health Care Provisions in H.R. 3962

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Summary

The 111th Congress has devoted considerable effort to health reform that seeks to increase health insurance coverage for more Americans and help control increasing costs while improving quality and patient outcomes. H.R. 3962, the Affordable Health Care for America Act, was introduced in the House of Representatives on October 29, 2009. H.R. 3962 is based on H.R. 3200, America's Affordable Health Choices Act of 2009, which was originally introduced on July 14, 2009, and was reported separately on October 14, 2009, by three House Committees—Education and Labor, Energy and Commerce, and Ways and Means. One major difference between H.R. 3200 and H.R. 3962 is the addition of Division D, "Indian Health Care Improvement," which would reenact, authorize, and amend the Indian Health Care Improvement Act (IHCIA). Division D differs from much of the other divisions of H.R. 3962 in that it targets a specific population group—American Indians and Alaska Natives, a group that, in general, has lower health status, lower life expectancy, and higher rates of a number of diseases, including diabetes, than the U.S. population as a whole. The goal of the division—to improve the health of American Indians and Alaska Natives—is consistent with the changes proposed in other divisions that also propose to improve health care access and quality, augment the health care workforce, and increase access to mental health services.

This report summarizes the provisions of Division D of H.R. 3962. The division contains two titles. Title I contains three sections (3101-3103), of which Section 3101(a) reenacts, amends, and reauthorizes all eight titles of IHCIA. Section 3101(a) contains IHCIA's general provisions and its eight titles: (1) Indian health workforce, (2) health services, (3) health care and sanitation facilities, (4) access to federal reimbursements, (5) health services for urban Indians, (6) Indian Health Service (IHS) organizational improvements, (7) behavioral health programs, and (8) miscellaneous. Section 3101(b) and (c) and Sections 3102 and 3103 make changes to Indian programs, including technical corrections to other federal laws. Title II of Division D contains five sections (Sections 3201-3205), three of which amend the Social Security Act (SSA) as related to American Indians and Alaska Natives. None of these sections amend IHCIA.

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Introduction

The 111th Congress has devoted considerable effort to health reform that seeks to increase health insurance coverage for more Americans and help control increasing costs while improving quality and patient outcomes. H.R. 3962, the Affordable Health Care for America Act, was introduced in the House of Representatives on October 29, 2009. H.R. 3962 is based on H.R. 3200, America's Affordable Health Choices Act of 2009, which was originally introduced on July 14, 2009, and was reported separately on October 14, 2009, by three House Committees—Education and Labor, Energy and Commerce, and Ways and Means. One major difference between H.R. 3200 and H.R. 3962 is the addition of Division D, "Indian Health Care Improvement," which would reenact, authorize, and amend the Indian Health Care Improvement Act (IHCIA).[1] Division D differs from much of the other divisions of H.R. 3962 in that it targets a specific population group—American Indians and Alaska Natives, a group that, in general, has lower health status, lower life expectancy, and higher rates of a number of diseases, including diabetes, than the U.S. population as a whole. The goal of the division—to improve the health of American Indians and Alaska Natives—is consistent with the changes proposed in other divisions that also propose to improve health care access and quality, augment the health care workforce, and increase access to mental health services.

Overview of Indian Health Care

The Indian Health Service (IHS), an agency in the Department of Health and Human Services (HHS), provides health care for approximately 1.8 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[2] IHS is organized into 12 Areas administered by an Area Office; Areas, in turn, are further subdivided into service units. IHS may provide services directly, or Indian tribes (ITs) or tribal organizations (TOs) may operate IHS facilities and programs themselves through self-determination contracts and self-governance compacts negotiated with IHS.[3] Urban Indian Organizations (UIOs) also provide services using contracts and grants from IHS.

IHCIA authorizes many specific IHS activities,[4] sets out the national policy for health services administered to Indians, and states the federal goal for the health condition of the IHS service population, which is to "assure the highest possible health status for Indians and urban Indians."[5] Significantly, IHCIA also authorizes direct collections from Medicare, Medicaid, and other third party insurers. IHCIA also gives IHS authority to grant funding to urban Indian organizations to provide health care services to urban Indians, and establishes substance abuse treatment programs, Indian health professions recruitment programs, and many other programs. The IHCIA

[1] P.L. 94-437, act of September 30, 1976, 90 Stat. 1400, as amended; 25 U.S.C. 1601 et seq., and 42 U.S.C. 1395qq, 1396j (and amending other sections).

[2] Additional information about IHS can be found in CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke.

[3] Authorized by P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

[4] CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke.

[5] IHCIA, §3(a); 25 U.S.C. 1602(a).

was last fully reauthorized by the Indian Health Amendments of 1992,[6] which extended authorizations of its appropriations through FY2000. In 2000, all IHCIA appropriations authorizations were extended through FY2001.[7] Congress has continued to appropriate funds for IHCIA programs since 2001.[8] IHCIA reauthorization has been under consideration in Congress since 1999.[9] In the current Congress, IHCIA reauthorization bills were introduced in the House (H.R. 2708) and the Senate (S. 1790).

Another act, the Snyder Act of 1921,[10] provides an additional, but very general, authorization for Indian health programs. The Snyder Act is a permanent, indefinite authorization for federal Indian programs, including for "conservation of health." In 1921, all Indian programs, including health, were under the management of the Bureau of Indian Affairs (BIA) in the Department of the Interior (Interior). The Snyder Act was passed in order to authorize all the activities the BIA was then carrying out. The act's broad language might be read as authorizing—although not requiring—nearly any Indian program, including health care, for which Congress enacts appropriations. The act, however, gives no directions or policies for federal Indian health care. When Congress transferred Indian health care programs from the BIA to the Public Health Service (PHS) in the then-Department of Health, Education, and Welfare (predecessor to the Department Health and Human Services (HHS)) in 1954,[11] the Snyder Act's authorization accompanied the transfer.

Overview of Report

The Affordable Health Care for America Act (H.R. 3962), as introduced on October 29, 2009, proposes sweeping reforms of the U.S. health insurance and health care system. H.R. 3962 contains four major divisions: A, B, C, and D. Division A, "Affordable Health Care Choices," focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. Division B, "Medicare and Medicaid Improvements," proposes modifications to the largest two health insurance programs to make them consistent with the changes proposed in Division A and to amend other provisions in existing federal statute. Division B also introduces a number of technical changes intended to improve quality of care, reduce federal and state expenditures, and address coverage gaps for both Medicare and Medicaid. Division C, "Public Health and Workforce Development," would amend and expand existing health professions and nursing workforce programs. Division D, "Indian Health Care Improvement," would reenact, authorize, and amend the Indian Health Care Improvement Act (IHCIA). This report does not discuss other Divisions of H.R. 3962; reports on these divisions can be found at CRS's website under "Issue in Focus-Health Reform."[12] Proposals

[6] P.L. 102-573, act of October 29, 1992, 106 Stat. 4526.

[7] Omnibus Indian Advancement Act, P.L. 106-568, §815, act of December 27, 2000, 114 Stat. 2868, 2918.

[8] For a discussion of the relationship between appropriations and authorizations, see CRS Report RS20371, *Overview of the Authorization-Appropriations Process*, by Bill Heniff Jr.

[9] IHCIA reauthorization bills were introduced in the 106th (H.R. 3397 and S. 2526), 107th (S. 212 and H.R. 1662), 108th (S. 556 and H.R. 2440), 109th (H.R. 5312, S. 1057, S. 3524, and S. 4122), and 110th (H.R. 1328, S. 1200, and S. 2532) Congresses.

[10] P.L. 67-85, act of Nov. 2, 1921 42 Stat. 208, as amended; 25 U.S.C. 13.

[11] P.L. 83-568, act of August 5, 1954, 68 Stat. 674, as amended; 42 U.S.C. 2001 et seq.

[12] See http://crs.gov/Pages/subissue.aspx?cliid=3746&parentid=13.

in other divisions of H.R. 3962 may also affect American Indians and Alaska Natives. For example, Indian tribes may be eligible for grant or contract programs proposed in H.R. 3962 or may benefit from proposed Medicaid reforms.

This report summarizes the provisions of Division D of H.R. 3962, including those offered as part of a Manager's amendment introduced on November 3, 2009.[13] The division contains two titles. Title I contains three sections. Section 3101(a) reenacts, amends, and reauthorizes all eight titles of IHCIA. Section 3101 (b) and (c) and Sections 3102 and 3103 make changes to Indian programs, including technical corrections to other federal laws. Title II of Division D contains five sections (Sections 3201-3205), three of which amend sections of the Social Security Act (SSA), and none of which amend IHCIA. This report summarizes the major sections of Division D; for analysis of selected provisions and issues in each title of IHCIA and related SSA programs, see pages 22-50 of CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke.

The first part of this report covers Title I of Division D, especially Section 3101(a). Section 3101(a) contains IHCIA's general provisions and its eight titles: (1) Indian health workforce, (2) health services, (3) health care and sanitation facilities, (4) access to federal reimbursements, (5) health services for urban Indians, (6) IHS organizational improvements, (7) behavioral health programs, and (8) miscellaneous. Most authorizations of appropriations are included in the final section of each IHCIA title. Division D would make each title's authorizations of appropriations permanent and indefinite (as noted above, appropriations authorizations in the current IHCIA expired in FY2000). Sections that include only appropriations authorizations are not summarized in the discussions below.

This report's second part covers Title II of Division D. Title II (Sections 3201-3205) includes provisions related to improving Indian health care provided through federal health programs authorized in the Social Security Act (SSA)—Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These sections amend the SSA and cross-reference a number of provisions included in Section 3101(a), especially IHCIA Title IV, which, among other things, amends the current IHCIA as it relates to these SSA programs. These two titles will be discussed separately with appropriate cross-references. For Title I of Division D, in most instances, the discussion of each IHCIA title begins with some background on current law to provide context for the descriptions of the bill's provisions.

The **Appendix** includes a list of acronyms used in this report. The Children's Health Insurance Program Reauthorization Act of 2009[14] renamed the State Children's Health Insurance Program and its acronym, SCHIP. The program is now the Children's Health Insurance Program, or CHIP. The text of Division D in H.R. 3962 refers to this program as SCHIP, but this report uses the new acronym, CHIP. The term "Secretary," as used in this report, means the Secretary of HHS, unless otherwise indicated. The term "Indian" in this report refers to "Indian" as defined in IHCIA and maintained in Section 4 below. Under this definition, an Indian is a person who is a member of a federally recognized tribe, band, nation, or other organized group or community, including any Alaska Native village or group, or regional or village corporation, as defined in or established

[13] See http://docs.house.gov/rules/health/111_hr3962_dingell.pdf for text of the Manager's amendment.

[14] P.L. 111-3, act of Feb. 4, 2009, 123 Stat. 8.

pursuant to the Alaska Native Claims Settlement Act. [15] The report also includes, in footnotes, instances where there are potential technical errors in the bill.

This report will be updated to reflect future legislative actions.

Title I of Division D: IHCIA Reauthorization

Federal Indian Health Policy and IHCIA Definitions

Section 3. Declaration of National Indian Health Policy

This section would declare that national policy, in fulfillment of special responsibilities and legal obligations to Indians, is to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect the policy; to raise Indian and urban Indian health status to that set forth in the Healthy People 2010 national health agenda;[16] to allow Indians to the greatest extent possible to set their health care priorities; to increase health professions degrees awarded to Indians so that the proportion of Indian health professionals is the same as the general population in each IHS area; to require meaningful consultation with ITs, TOs, and UIOs; and to fund Indian-operated programs and facilities at the same level as IHS-operated programs and facilities.

Section 4. Definitions

This section would define 28 terms. It would maintain 12 definitions in current law, amend five current definitions, delete three terms, and define 11 new terms. The new terms include "accredited and accessible", "Assistant Secretary", "behavioral health," "California Indians," "contract health service," "Department," "Indian Health Program," "reservation," "telehealth," "telemedicine," and "Tribal Health Program."

The report uses the following terms: "Indian Health Program" (IHP), which is defined as any health program administered by the IHS or by an IT or TO under either the Indian Self-Determination and Education Assistance Act, as amended (ISDEAA),[17] or the Buy Indian Act;[18] and "Tribal Health Program" (THP), which is defined as any tribe or tribal organization operating a health program under ISDEAA. THPs are included within the term IHP.

[15] P.L. 92-203, act of Dec. 18, 1971, 85 Stat. 688, as amended; 43 U.S.C. 1601 et seq.

[16] See http://healthypeople.gov/.

[17] P.L. 93-638, act of Jan. 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

[18] 25 U.S.C. 47

Indian Health Workforce[19]

IHCIA Title I in Section 3101(a) includes provisions related to personnel recruitment, scholarships, and other educational programs that would address the Indian health workforce. IHS has high vacancy rates in many of its health professions—over 20% for physicians, dentists, and nurses, for instance, as of December 2008.[20] The purpose of IHCIA Title I is to increase the number, and also enhance the skills, of Indian and non-Indian health professionals and other health personnel in the IHS. To do this, the title would authorize scholarships for preparatory and professional schools. Compared with current law, H.R. 3962 would add UIO programs and employees, where possible, as eligible for workforce programs. It would also expand the right to a "retention bonus" to all health professionals employed in or assigned to IHP or UIO programs.

Section 102. Health Professions Recruitment Program for Indians

This section would authorize grants to THPs or UIOs, and public and nonprofit entities for recruitment programs, to include identifying Indians with potential for entering health professions, publicizing funding sources, and establishing programs to facilitate enrollment in health professions courses of study. This section also includes requirements for funding applications, and the amount of funding, in addition to outlining the eligibility for these programs, and establishing a three year grant period.

Section 103. Health Professions Preparatory Scholarship Program for Indians

This section would authorize scholarships to Indians for compensatory pre-professional education as well as undergraduate education leading to a baccalaureate degree in a preparatory field for a health profession. The pre-professional scholarships would be awarded for up to two years on a full-time basis, and undergraduate scholarships would be awarded for up to four years (with an extension of up to two years). This section also would specify the expenses covered by the scholarship and would specify that scholarships cannot be denied on scholastic achievement if the applicant has already been admitted or maintains good standing at an accredited institution, or denied because of the applicant's eligibility for assistance under other federal programs.

Section 104. Indian Health Professions Scholarships

This section would authorize scholarships to Indians enrolled full- or part-time in accredited schools pursuing courses of study in the health professions, in accordance with Section 338A of the Public Health Service Act[21] (PHSA). Scholarship recipients would be obligated to serve at an IHS, THP, or urban Indian health project (UIHP), or in a private practice located in a health professional shortage area that has a substantial number of Indians, for the greater of either one

[19] Division C of H.R. 3962 includes provisions that would create new or reauthorize a number of existing workforce and public health programs, in a number of cases IT and TO may be eligible for these programs. See CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

[20] U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, *Indian Health Service: Fiscal Year 2010 Justification of Estimates for Appropriations Committees* (Rockville, MD: HHS/PHS/IHS, 2009), pp. CJ-147 to CJ-148; http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/documents/IHS_CJ_2010_Final_Submission.pdf

[21] 42 U.S.C. 254*l*.

year for each scholarship year or two years. The section would also authorize the Secretary to allocate scholarships among health professions based on health services needs, specify guidelines for fulfilling the service obligation in private practice or through teaching, set sanctions for failure to complete service obligations, and permit the Secretary to waive the service obligation under certain circumstances.

Section 105. American Indians into Psychology Program

This section would authorize the Secretary, acting through the IHS director, to establish a grant program to award grants of not more than $300,000 to each of nine colleges and universities for developing and maintaining Indian psychology career recruitment programs. The sections would require that one grant be awarded to the University of North Dakota to establish a "Quentin N. Burdick American Indians into Psychology Program." The section would also require that grants be awarded to locations throughout the United States to maximize their availability to Indian students, including grants at new locations. In addition, the section would require the Secretary to issue regulations for competitive funding, and would specify conditions of the grants, including recipients' service obligations. The section would authorize an appropriation of such sums as may be necessary to carry out this section.

Section 106. Scholarship Programs for Indian Tribes

This section would require the Secretary, acting through IHS, to make matching grants to ITs or TOs for scholarships to educate Indians to serve as health professionals in Indian communities. The section would require that entities receiving grants match 20% of the funds. The section would specify (1) the requirements for receiving such funds, the course of study, contract conditions, and specific parameters for a breach of contract; (2) that individuals receiving scholarships would not be permitted to discriminate against patients who receive assistance through the Medicare, Medicaid, and CHIP programs; and (3) the conditions of continuance of funding. Recipients would be required to use the scholarship for tuition and reasonable education or living expenses, to meet their health professions' licensing and educational requirements, and to fulfill service obligations. Recipients may serve in another IHS Area if the tribe and IHS approve and if services are not diminished in the contracting tribe's Area.

Section 107. Indian Health Service Extern Programs

This section would require that recipients of scholarships under IHCIA Sections 104 or 106 receive preference for IHS employment and authorized employment with IHS, tribal, or urban Indian health programs or with other HHS agencies, during non-academic parts of a year, without regard to competitive or agency personnel limitations. The section would specify that such employment would not be counted towards any active duty service obligation. The section would also authorize an extern program for enrollees in health professions recruitment programs under IHCA Section 102(a), including high school programs, and would specify the timing and length of such employment.

Section 108. Continuing Education Allowances

This section would authorize the Secretary to provide programs or allowances to encourage specified health professionals and scholarship and stipend recipients under IHCIA Sections 104,

105, 106, and 115 to join or continue in IHS and THPs, and to work in rural or remote areas where significant numbers of Indians reside. These programs or allowances may be used to help individuals to transition into IHPs, including licensing and board or certification examination assistance and technical assistance in fulfilling service obligations. The section would also authorize programs and allowances for IHS and tribal health professionals to take leave of their duty stations for a period of time each year for specified continuing professional education.

Section 109. Community Health Representative Program

This section would require the Secretary to establish through IHS, IT, and TOs a program of health paraprofessionals, called Community Health Representatives (CHRs), to provide health care, health promotion, and disease prevention services in Indian communities. The section would require the Secretary to establish training and continuing education for CHRs, provide supervision and evaluation systems, and promote traditional tribal health care practices as consistent with IHS standards for health care.

Section 110. Indian Health Service Loan Repayment Program

This section would require the Secretary to establish a loan repayment program for health professionals who contract to work for a specified time for, or are already employed by, IHPs or UIHPs. The section would specify the individuals eligible for the program and the program's application, selection, and notification processes. It would further specify that the program would give first priority to Indian applicants. The loan repayment program would include payment of principal, interest, and related expenses of school loans up to $35,000 for each year of obligated service and, in addition to this payment, may include an amount to cover tax liability incurred for this payment. This section also includes a number of other program requirements, such as those related to assigning individuals and recruitment programs, and it includes a required annual report to Congress.

Section 111. Scholarship and Loan Repayment Recovery Fund

This section would establish, within the Department of the Treasury, an Indian Health Scholarship and Loan Repayment Recovery Fund (Fund), consisting of amounts that may be collected from contract breaches under IHCIA Sections 104, 106, and 110, plus any appropriation to the Fund and interest. The section authorizes Fund payments to THPs with health professional needs resulting from breaches of contracts under the three programs, and allows THPs receiving such payments to use them for scholarships and recruitment or employment of health professionals. The section would also require the Secretary of the Treasury to invest any amounts in the Funds that the HHS Secretary determines are not needed to meet current withdrawals.

Section 113. Indian Recruitment and Retention Program

This section would require the Secretary to fund, on a competitive basis, demonstration projects to enable IHPs and UIOs to recruit, place, and retain health professionals to meet their staffing needs. The section would specify that any IHP or UIO may apply for these funds, and limits funding for a project to three years.

Section 114. Advanced Training and Research

This section would require the Secretary to establish a program to enable health professionals who have worked for an IHS, THP, or UIHP for a substantial period of time to pursue advanced training or research in areas of study where the Secretary determines a need exists. The section would obligate participants to work for an equivalent period for IHS or a tribal or urban health program, make participants failing to complete such service liable to the United States for the remaining service period, and require equal opportunity to participate in the program for ITs and TOs.

Section 115. Quentin N. Burdick American Indians into Nursing Program

This section would require the Secretary to make grants to nursing schools, tribally-controlled community and vocational colleges, and nurse-midwife and advanced practice nurse programs to increase the number of nurses serving Indians, through scholarships, recruitment, continuing education, or other programs encouraging nursing services to Indians. The section would specify the criteria that the Secretary would be required to use when making grant awards, and would require that one grant be for the establishment of the "Quentin N. Burdick American Indians into Nursing Program" at the University of North Dakota. The section would specify the uses of grants and the required service obligations for individuals who receive a scholarship under this section. The section would also require that applicants show a connection to a health facility primarily serving Indians.

Section 116. Tribal Cultural Orientation

This section would require the Secretary to establish a mandatory training program, for appropriate IHS employees serving tribes in each IHS Area, in the history and culture of the tribes they serve and the tribes' relationship to IHS. The section would require the Secretary, to the extent feasible, to develop the program in consultation with the affected ITs , TOs, or UIOs, to implement the program, which includes instruction in Native American studies and traditional health care practices, through tribal community and vocational colleges.

Section 117. INMED Program

This section would authorize the Secretary to provide grants to colleges and universities to maintain and expand the Indian health careers recruitment program ("Indians Into Medicine Program," or "INMED"), and would require that one of the grants go to the "Quentin N. Burdick Indian Health Programs" at the University of North Dakota. The section would also specify the requirements and regulations for the grant program.

Section 118. Health Training Programs of Community Colleges

This section would require the Secretary to award grants to accredited and accessible community colleges to assist in establishing health profession education programs leading to a degree or diploma for individuals desiring to practice on or near an Indian reservation or in an IHP. The section would set the maximum first year grant at $250,000. The section would also require the Secretary to award grants to community colleges that already have such programs, and to provide technical assistance and qualified IHS personnel to teach courses. The section would set

eligibility requirements for colleges and would give priority to tribally-controlled colleges in IHS Areas if other requirements in the section are met, and would require grantees to provide Indian preference for program participants and advanced training for health professionals.

Section 119. Retention Bonus

This section would authorize the Secretary to pay retention bonuses to any health professional employed by an IHS, TO, or UIO, in needed positions for which recruitment is difficult, who agree to continue their current employment with IHS, a THP, or UIHP for not less than one year. The health professional must have completed two years of employment in an IHS, IHP, or UIO, or any service obligation from federal scholarships or loan repayment programs. Retention bonuses may be higher for multiple years but may not exceed an annual rate of $25,000. The section would require that the health professional refund the bonus if the term of service is not completed, unless the default is not the fault of the individual.

Section 120. Nursing Residency Program

This section would require the Secretary to establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses working for an IHP or UIO for at least one year to pursue advanced training in a residency program. The program shall include a combination of education and work study leading to either an associate or bachelor's degree for specified nursing disciplines or to any advanced degree or certification in nursing and public health. The section would require that participants incur a service obligation time period that is twice the period of time in the program for professional nurses and the same as the period of time in the program for nonprofessional nurses.

Section 121. Community Health Aide Program

This section would require the Secretary, under authority of the Snyder Act, to develop and operate a Community Health Aide Program (CHAP) in Alaska, under which IHS trains Alaska Natives to provide health care, health promotion, and disease prevention in rural Alaska Native villages. The section would require the Secretary to provide, in a specified manner, a high standard of training to community health aides, to establish a CHAP certification board, and to provide continuing education, close supervision, and a system to review and evaluate CHAP work. The section would prohibit a CHAP dental health aide therapist from performing certain pulpal therapy or extractions without a determination of a medical emergency by a licensed dentist and from performing any other oral or jaw surgeries except for uncomplicated extractions.

The section would also authorize the expansion of CHAP, except for the dental health aide therapist program, into a national program, but would require that the expansion not reduce Alaska CHAP funding. The section would require the Secretary to establish a neutral review panel to study the CHAP dental health aide therapist program to ensure that the quality of care is adequate and appropriate. The section would also specify panel membership, and the factors of the study, and would require consultation with Alaska tribal organizations and a report to Congress.

Section 122. Tribal Health Program Administration

This section would require the Secretary to provide training to Indians in the administration and planning of THPs.

Section 123. Health Professional Chronic Shortage Demonstration Programs

This section would authorize the Secretary to fund demonstration programs for THPs to address chronic shortages in health professionals. The section would specify the purposes of the demonstration programs, and would require that the programs incorporate an advisory board composed of representatives from tribes and Indian communities served by the program.

Section 124. National Health Service Corps

This section would prohibit the Secretary from removing a member of the National Health Service Corps[22] (NHSC) from an IHS, IHP, or UIO, or withdrawing funding to support such member, unless the Secretary ensures that Indians will experience no reduction in services. The section would authorize that, at the IHP's request, the services of NHSC personnel may be limited to only the persons eligible for services from that IHP.

Section 125. Substance Abuse Counselor Educational Demonstration Programs

This section would authorize the Secretary to enter into contracts with or make grants to accredited and accessible tribal community colleges, tribal vocational colleges, and eligible community colleges to establish demonstration programs developing educational curricula for substance abuse counseling. The section would limit grants to three years, with a two year renewal, and would require the Secretary (in consultation with tribes, tribal and community colleges, and eligible community colleges) to issue criteria for approval of applications. The section would also require the Secretary to provide technical and other assistance to grant recipients, and submit an annual report to the President for inclusion in the annual report to Congress. The section would define the term "educational curriculum."

Section 126. Behavioral Health Training and Community Education Programs

This section would require the Secretary and the Secretary of the Interior, in consultation with IT and TOs, to conduct a study and compile a list of specified types of staff positions within the BIA, IHS, ITs, TOs, and UIOs whose qualifications should include training in the identification, prevention, education, referral, or treatment of mental illness, dysfunction, or self-destructive behavior. The appropriate Secretary would be required to provide training criteria appropriate for each type of position and to ensure that this training is provided. The Secretary would be required, upon request by a IT, TO, or UIO, to develop and implement a program of community education on mental illness, or assist the requester with doing so. The section would also require the Secretary to provide technical assistance for obtaining and developing community education

[22] For more information on the this program, see CRS Report R40533, *Health Care Workforce: National Health Service Corps*, by Bernice Reyes-Akinbileje. Proposed changes to this program in H.R. 3962 can be found in CRS Report R40892, *Public Health, Workforce, Quality, and Related Provisions in H.R. 3962*, coordinated by C. Stephen Redhead.

materials. Within 90 days of enactment, the Secretary would be required to develop a plan, to be implemented under the Snyder Act, to increase behavioral health services by at least 500 staff positions within five years, with at least 200 of such positions devoted to child, adolescent, and family services.

Section 127. Exemption from Payment of Certain Fees

This section would exempt employees of a THP or UIO from the payment of licensing, registration, and other fees imposed by a federal agency, to the same extent that PHS Commissioned Corps officers or other IHS employees are exempt from the fees.

Health Services

IHCIA Title II in Section 3101(a) would authorize a number of specific non-behavioral-health programs and activities, including prevention activities, diabetes and cancer programs, Indian men's health, Indian school health education programs, research and epidemiological centers, and a fund for the elimination of funding inequities among health care programs. The title would also define the contract health service (CHS) delivery areas in several states. CHS refers to services that IHS, ITs, or TOs may purchase, through contract, from private providers in instances where the THP cannot provide the needed care.

Section 201. Indian Health Care Improvement Fund

This section would authorize the use of funds, designated as the "Indian Health Care Improvement Fund" (IHCIF), to eliminate tribes' deficiencies in health status and resource (as defined in the section), eliminate backlogs in provision of health care to Indians, meet health needs efficiently and equitably, eliminate inequities in funding for both direct care and CHS, and augment the ability of IHS to meet 10 specified health service responsibilities. The Secretary would be authorized to expend IHCIF funds either directly or through contracts or compacts under ISDEAA. The section would prohibit using funds appropriated under this section to offset funds appropriated under other laws, allow IHCIF allocation among service units and THPs, and require the Secretary to determine (with the participation of affected tribes and tribal organizations) the apportionment of funds among service units, tribes, and tribal organizations for the specified health service responsibilities. The section would make THPs equally eligible for funds with IHS programs and would require that appropriations under this section be included in the base budget of the IHS for subsequent fiscal years. The section would also require a report to Congress three years after enactment on the current health status and resource deficiencies for each tribe or service unit, and would specify the data to be included in the report. In addition, the section would specify that nothing in the section is intended to diminish the primary responsibility of the IHS to eliminate backlogs in unmet health care or to discourage additional efforts by IHS to achieve parity among tribes.

Section 202. Health Promotion and Disease Prevention Services

This section would make a congressional finding that health promotion and disease prevention activities improve the health and well-being of the Indian population while reducing health care expenses. It would require the Secretary to provide such services to Indians in order to meet the act's health status objectives, and would require the Secretary, after receiving input from THPs, to

submit to the President an evaluation statement of the resources required to undertake these health promotion and disease prevention activities. This evaluation statement would be included in annual reports to Congress.

Section 203. Diabetes Prevention, Treatment, and Control

This section would require the Secretary to determine the incidence of diabetes and its complications among Indians and, based on the incidence determined, what actions IHS service units would need to take to prevent, treat, and control the disease, including effective ongoing monitoring. The Secretary would be required to screen Indians for diabetes and for conditions that indicate a high risk for diabetes; it would require that such screenings be medically indicated and conducted with informed consent. The section would also permit screening through Internet-based programs, and would require the Secretary to establish a cost-effective approach to ensure ongoing monitoring of diabetes indicators. In addition, the section would require the Secretary to maintain existing model diabetes projects and authorize the Secretary to provide dialysis programs for IHS, ITs, and TOs, including equipment and staffing. The Secretary would be required to consult with the ITs and TOs in each IHS area on diabetes programs, establish diabetes patient registries in each IHS Area Office, and ensure that the data collected are disseminated to other Area Offices. The section would also authorize diabetes control officers in each IHS Area Office.

Section 204. Shared Services for Long-Term Care

This section would authorize the Secretary to provide, directly or through ISDEAA contracts or compacts with THPs, long-term care and health care services associated with long-term care at any long-term care or related facility owned or operated by a THP directly or under ISDEAA. The section would require that the agreements provide for sharing staff and other services between an IHS facility and the contracting IT's or TO's facility. The section would authorize such contracts to allow delegation to the contractors of necessary supervision over IHS employees, and would allow ITs and TOs to construct, renovate, or expand nursing facilities. The section would also specify certain terms of the agreement, including funding allocations, and would also specify that any nursing facility funded under this section must meet the requirements for such facilities under Medicare statute. The section would also require the Secretary to provide necessary technical and other assistance to tribal applicants, and to encourage the use of existing underused facilities or allow the use of swing beds, for long-term or similar care.

Section 205. Health Services Research

This section would authorize funding for clinical and nonclinical research to further the performance of IHPs' responsibilities. The section would require the Secretary to coordinate HHS research resources and activities to address IHP research needs, to the maximum extent practical. The section would also require that THPs have equal opportunity to compete for these research funds and would require the Secretary to evaluate the impact of the research conducted under this section and disseminate research findings to THPs as appropriate.

Section 206. Mammography and Other Cancer Screening

This section would require the Secretary to provide for screening mammography for Indian women, at a frequency determined appropriate under accepted national standards and under terms and conditions consistent with standards established by the Secretary under the SSA, to ensure the safety and accuracy of the mammography. The section also would require the Secretary to provide certain other cancer screening that complies with the recommendations of the United States Preventive Services Task Force (USPSTF) on specified factors.

Section 207. Patient Travel Costs

This section would authorize the Secretary, through IHS, to provide funds for specified patient travel costs associated with receiving IHS-funded health care services, including emergency air transport and non-emergency air transport where ground transport is not feasible; transportation by ambulance, specially equipped vehicle, or private vehicle where no other transportation is available; or other means required when air or motor vehicle transport is not available. The section would also authorize funding for qualified escorts, as defined in the section.

Section 208. Epidemiology Centers

This section would require the Secretary to establish an epidemiology center in each IHS Area to carry out seven specified functions, in consultation with ITs and tribal and urban Indian communities. An epidemiology center would be subject to ISDEAA. The section would require that the Director of the Centers for Disease Control and Prevention (CDC) provide technical assistance to these epidemiology centers. The section would also authorize the Secretary to make grants to tribes, tribal and urban Indian organizations, and eligible intertribal consortia (as defined) to operate an epidemiology center and to conduct epidemiological studies of Indian communities, and would specify the criteria for applicants and the uses of such grants. The section would further require that epidemiology centers operated under such grants be treated as public health authorities for purposes of the Health Insurance Portability and Accountability Act[23] (HIPAA). In addition, the section would require the Secretary to grant such centers access to and use of data, data sets, monitoring systems, delivery systems, and other protected health information in the Secretary's possession, and would specify that such centers' activities would be required to be, for purposes of HIPPAA, for research or disease prevention and control.

Section 209. Comprehensive School Health Education Programs

This section would authorize the Secretary to provide grants to ITs and TOs to develop comprehensive school health education programs for children from pre-school through grade 12 in schools for the benefit of Indian children. The section would specify the purposes for which grant funds may be used and would require the Secretary to provide technical assistance to ITs and TOs in developing and disseminating comprehensive health education plans, materials, and information, and, in consultation with these groups, to establish criteria for review and approval of grant applications. The section also would require the Secretary of the Interior, in consultation with the HHS Secretary, to develop similar school health education programs in BIA-funded

[23] P.L. 104-191, act of Aug. 21, 1996, 110 Stat. 1936, as amended.

schools.[24] In addition, the section would specify the subjects the programs must include, and it directs the Interior Secretary to provide teacher training, ensure coordination with community programs, and encourage healthy, tobacco-free school environments.

Section 210. Indian Youth Program

This section would authorize the Secretary to make grants to ITs, TOs, and UIOs for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths. The section would specify the criteria to review and approve applications, and the allowable and prohibited uses of the grants, and would require the Secretary to disseminate information to ITs, TOs, and UIOs regarding models for delivery of comprehensive health care services to Indian youth, encourage the implementation of these models, and provide technical assistance upon request. The section would also prohibit funds provided under this section to be used for Indian youth services described in IHCIA Section 707.

Section 211. Projects Related to Communicable and Infectious Diseases

This section would authorize the Secretary to make grants to ITs, TOs, and UIOs for projects to prevent, control, and eliminate communicable and infectious diseases, provide public information and education on such diseases, provide education and skills improvement activities on such diseases for health professionals, and establish demonstration projects for the screening, treatment, and prevention of the hepatitis C virus. Grant recipients would be encouraged to coordinate their activities with the CDC and state and local health agencies. The section would also authorize the Secretary to provide technical assistance, upon request, and would require the Secretary to make a biennial report to Congress.

Section 212. Other Authority for Provision of Services

This section would authorize the Secretary to provide funding, through programs and services of IHS, ITs, and TOs, for health-care-related services and programs (not otherwise specified in the act) for hospice care, assisted living, long-term care, and home- and community-based services. This section would also define these terms. "Assisted living services" would be defined as any service provided by an assisted living facility (as defined in Section 232 of the National Housing Act) although the facility would be exempt from having to obtain a license, but would be required to meet all applicable standards for licensure. "Home- and community-based services" would be defined as certain services listed in SSA Section 1929 that are or will be provided in accordance with applicable standards. "Hospice care" would be defined as certain services listed in SSA Section 1861 and such other services as an IT or TO determines are necessary and appropriate to provide in furtherance of the hospice care. "Long-term care services" would be defined to be the same as "qualified long-term care services" in Section 7702B of the Internal Revenue Code of 1986 (IRC). The section would specify the criteria by which individuals would be eligible for long-term care. The section would also authorize funding, through IHS, tribes, and tribal organizations, for "convenient care services" pursuant to IHCIA Section 306.[25]

[24] The BIA's educational programs were transferred to a new agency, the Bureau of Indian Education (BIE), in 2006.

[25] This section would authorize convenient care as defined in IHCIA Section 306; however, this term is neither (continued...)

Section 213. Indian Women's Health Care

This section would require the Secretary, acting through IHS, ITs, TOs, and UIOs, to monitor and improve the quality of Indian women's health care delivered through programs administered by IHS.

Section 214. Environmental and Nuclear Health Hazards

This section would require the Secretary and IHS, in conjunction with other federal agencies and in consultation with concerned tribes and organizations, to conduct studies on trends in health hazards to Indian miners and Indians on or near reservations and in Indian communities as a result of environmental hazards which may result in chronic or life threatening health problems. The section would specify the subjects of the studies, and would require the Secretary and IHS, upon completion of the studies, to develop health care plans to address the health problems studied, including diagnosis, treatment, preventive care, testing, and education. The section would require the Secretary to submit the study to Congress 18 months after enactment and, no later than one year after the study, submit to Congress a report containing the health care plans, with recommendations for implementation. The section would also establish an Intergovernmental Task Force, chaired by the Secretary, to identify nuclear resource development or other environmental hazards and take corrective action. The section would require IHPs to provide medical care to IHS-eligible Indians who suffer from work-related conditions as a result of employment in uranium mines or mills on or near any other environmental hazard, would authorize reimbursement from the mine or mill operator or other responsible entity who would be responsible for the expense of such care.

Section 217. California Contract Health Services Program

This section would authorize the Secretary to fund a program using an intertribal consortium as a CHS intermediary to improve the accessibility of health services to California Indians. The section would require the Secretary to enter an agreement with an intertribal consortium to reimburse the intertribal consortium for costs incurred including limited administrative expenses while serving as a CHS intermediary. This section references the definitions of California Indians in Section 805 and the California CHS delivery area in Section 218.[26] This section also would specify that no payment may be made for treatment under this section to the extent payment may be made under the Catastrophic Health Emergency Fund (as described below) or from amounts appropriated or otherwise made available to the California CHS delivery area. This section would also establish an Advisory Board to advise the intertribal consortium in carrying out this section, to be comprised of representatives from not less than eight THPs serving California Indians covered under this section and at least one-half of whom are not affiliated with the intertribal consortium.

(...continued)

mentioned nor defined in IHCIA Section 306.

[26] This section references Section 219 for the California CHS area, the correct reference is Section 218.

Section 221. Licensing

This section would require that licensed health care professionals employed by a THP would be exempt from state licensing requirements while employed at a THP providing services under an ISDEAA contract or compact.

Section 222. Notification of Provision of Emergency Contract Health Services

This section would allow 30 days (as a condition of payment) for notifying IHS of any emergency medical care or services received by an elderly or disabled Indian from a non-IHS provider or in a non-IHS facility under the authority of this act.

Section 223. Prompt Action on Payment of Claims

This section would require IHS to respond to notification of a claim by a CHS provider within five working days of receipt of the notification, with either an individual purchase order or a claim denial. The section also provides that if IHS fails to respond within the required time, IHS would be required to accept the claim as valid. The section would require IHS to pay a valid CHS claim within 30 days after completion of the claim.

Section 224. Liability for Payment

This section would exempt a patient who receives IHS-authorized CHS from being held liable for any charges or costs associated with those authorized services. The section would also require the Secretary to notify the CHS provider and the patient who receives the services that the patient is not liable, within five business days of receipt of a notification of a claim by the provider. The section prohibits the CHS provider from recourse against the patient for payment if the notice has been received or if the claim has been deemed accepted under IHCIA Section 224.[27]

Section 225. Office of Indian Men's Health

This section would authorize the Secretary to establish the Office of Indian Men's Health in IHS, headed by a Director appointed by the Secretary, to coordinate and promote the health status of Indian men. The section would require the Secretary to submit a report to Congress within two years of enactment describing any activities and findings of the Director.

Section 226. Catastrophic Health Emergency Fund

This section would establish the Catastrophic Health Emergency Fund (CHEF), to be administered by the Secretary through the IHS central office, to meet extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses. The section would specify the uses, administration, and regulations of this fund. It would also specify that CHEF would consist of appropriations and third-party reimbursements to which IHS is entitled for treatments paid for by CHEF, and would require that no part of the CHEF or the administration thereof be subject to contract or grant. It also would require that CHEF not be apportioned on an

[27] The bill specifies Section 224; however, it is likely referring to Section 223.

Area Office, Service Unit, or any other basis. The section would also prohibit funds appropriated to CHEF from being used to offset or limit other IHS appropriations and requires that all reimbursements to which IHS is entitled from any source, by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from CHEF, be deposited into CHEF.

Health Care and Sanitation Facilities

IHCIA Title III of Section 3101(a) covers health care and sanitation facilities. IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities, for facilities operated by IHS and tribes. IHS also funds the construction of water supply and sewage facilities and solid waste disposal systems, and provides technical assistance for the operation and maintenance of such facilities. This title would set new requirements for closure of IHS-operated health care facilities, authorize a feasibility study for a new health-facility construction loan fund for ITs and TOs, and allow IHS to accept funding for health care facility construction from federal, state, and non-governmental sources.

Section 301. Consultation; Construction and Renovation of Facilities; Reports

This section would require that the Secretary, prior to expending or firmly committing to expend funds for planning, designing, constructing, or renovating facilities, consult with affected ITs and ensure that the facility meets the construction standards of any accrediting body recognized by the Secretary for the Medicare, Medicaid and CHIP programs. The section would prohibit closure of any IHS hospital or outpatient health care facility unless the Secretary has submitted to Congress not less than one year and not more than two years before the date of the proposed closure, an evaluation of the impact of the proposed closure, completed not more than two years before such submission, with specified information; temporary closures for medical, environmental, or construction safety reasons are exempted from this requirement. The section requires that the Secretary maintain a health care facility priority system that is developed in consultation with ITs and TOs that prioritizes tribal needs, includes the methodology for prioritization, and allows the nomination of new projects at least once every three years, and may include the top 10 priority facilities for five specified types of facilities as well as other facilities or needs as IHPs may identify. The section would prohibit a project's priority in effect at enactment from being affected by a new facility priority system if the project meets specified criteria and was identified in the FY2008 IHS budget justification as in the top 10 for five specified types of facilities.[28]

The section would also authorize the Secretary to establish a Facilities Appropriations Advisory Board and a Facilities Needs Assessment Workgroup, and would require the Secretary to submit to specified committees of Congress an initial report with a national ranked list of all IHPs health care facilities needs developed for the board and workgroup, and would require the Secretary to update the report every five years beginning in 2011. The section would also require the Secretary to submit to the President, for inclusion in reports to Congress, an annual report describing the new health care facility priority system and its methodology and listing top 10 facilities for 5 specified types of facilities with justifications and projected costs; the Secretary would be required to prepare the annual report in consultation with ITs, TOs, and UIOs and would be

[28] The five types of facilities are: inpatient health care facilities, outpatient health care facilities, specialized health care facilities (e.g., long-term care facilities), wellness centers, and staff quarters.

required to review the ITs' and TOs' total unmet facility needs. The section would also require the U.S. Government Accountability Office (GAO) to study the methodologies used by IHS in developing the health care facility priority system and making facility needs assessments, and report to specified committees of Congress and the Secretary. The section would require the Secretary to cooperate with ITs, TOs, and UIOs in developing innovative approaches to address unmet facility needs. The section would also make facility funds appropriated under the Snyder Act subject to ISDEAA.

Section 302. Sanitation Facilities

This section would provide Congressional findings on water and sanitary systems and Indian communities; would affirm IHS's primary responsibility and authority to provide sanitation facilities and services; would authorize financial and technical assistance to IT, TO, and Indian communities for utility organizations to operate sanitation facilities; and would authorize priority funding for operation or maintenance assistance (including emergency repairs) to avoid imminent health threats or protect the investment in health benefits gained through the sanitation facilities. The section would authorize the Secretary of Housing and Urban Development (HUD) to transfer funds appropriated under the Native American Housing and Self-Determination Act[29] to the HHS Secretary, but would prohibit the use of IHS funding for new homes constructed using HUD funds (unless authorized when appropriated).

The section would authorize the Secretary to accept sanitation facility funds from a variety of sources, would authorize the Secretary to use Indian Sanitation Facilities Act funding to fund tribes' federal loans or meet matching or cost participation requirements to construct sanitation facilities; would require the Secretary to enter into federal interagency agreements for financial assistance for sanitation facilities; and would require the Secretary to establish standards, by regulation, for the planning, design and construction of sanitation facilities. In addition, the section would require that the financial and technical capability of an IT, TO, or Indian community to safely operate and maintain a sanitation facility would not be a prerequisite to the provision or construction of sanitation facilities by the Secretary. The section would assign ITs primary responsibility for collecting user fees and other funding to operate and manage sanitation facilities, but would authorize the Secretary to assist the operating tribe or organization when a facility is threatened with imminent failure. The section would also require that THPs be equally eligible with IHS for funds appropriated under this section or to provide sanitation facilities. The section would also require the Secretary submit to the President, for inclusion in reports to Congress, an annual report (developed in consultation with IT, TOs, HUD, and tribally-designated housing entities) on the current IHS sanitation facility priority system, the level of sanitation deficiency (as defined in the section) for each sanitation facilities project, the funding necessary to raise all ITs and communities to the highest sanitation levels, and a 10-year plan to provide sanitation facilities to existing, renovated, and new Indian homes and to Indian communities. The Secretary would be authorized to provide to ITs, TOs, and Indian communities the federal share of the costs of operating and maintaining the facilities described under the 10-year plan. The section would define the term "Indian community," and defines "sanitation facilities" to include safe and adequate water supply systems, sanitary sewage and solid waste disposal systems, and all related equipment and support infrastructure.

[29] P.L. 104-330, act of Oct. 26, 1996, 110 Stat. 4017, as amended; 25 U.S.C., Chap. 43 and other sections, and various sections in Titles 12 and 42, U.S. Code.

Section 303. Preference to Indians and Indian Firms

This section would authorize the Secretary to use the Buy Indian Act to give Indians and Indian firms (as defined in the section) preference in the construction of IHS health care and sanitation facilities pursuant to IHCIA Sections 301 and 302 discussed above. This section would permit such preference unless the Secretary finds that the contracted project, under specified factors, would not be satisfactory or cannot be properly completed or maintained. The section would require the Secretary to assure that pay rates for construction or renovation of facilities under IHCIA Title III are not less than the prevailing local wage rates as determined in accordance with the Davis-Bacon Act,[30] and direct that contracts for construction or renovation of facilities under IHCIA must also comply with the Davis-Bacon Act.

Section 304. Expenditure of Non-Service Funds for Renovation

This section would authorize the Secretary to accept any major renovation, expansions, or modernization by an IT or TO of any IHS facility or any health facility operated under ISDEAA. The section would set criteria for accepting such renovation, expansion, or modernization. In addition, the section would require the Secretary to maintain a separate priority list for such facilities' needs for increased operating expenses, personnel, and equipment and develop and revise the methodology for establishing the priority list annually in consultation with IT and TO. The Secretary would also be required to include the priority list in a report submitted to the President for inclusion in annual reports to Congress. The section would require ITs and TOs to provide the Secretary with staffing, equipment, and other costs of facility expansions. The section would also authorize an IT that completed such a renovation or modernization to recover the prorated value of the facility if the facility ceases to be used as an IHS facility within 20 years after completion.

Section 305. Funding for Small Ambulatory Care Facilities

This section would require the Secretary to make grants to ITs and TOs for THPs to construct, expand, or modernize small ambulatory care facilities. The section would establish criteria for eligible facilities, including providing at least 150 patient visits annually in a service area with at least 1,500 eligible Indians (unless the facilities are on an island or are without road access to an inpatient hospital). The section would also permit a portion of funds to be used for debt reduction for ITs or TOs that built, expanded, or modernized facilities. For all grants awarded, the section would require that funding be used for the portion of costs which benefits the eligible population. The section would require that grants be approved under regulations, would require certain assurances of grant applicants, would assign grant priority to applicants demonstrating need, and would authorize the Secretary to use peer review panels to evaluate applications. The section would require that funding provided under this program is not recurring and would exclude such grant funding from calculations of a tribe's tribal shares under ISDEAA. The section would also require that the facility would revert to the United States if it ceases to be used to provide ambulatory care services to Indians.

[30] 40 U.S.C. 3141-3144, 3146, 3147.

Section 306. Indian Health Care Delivery Demonstration Project

This section would authorize the Secretary to make grants to, or construction contracts or agreements with, IT and TOs under ISDEAA to establish demonstration projects to test alternative health care delivery systems through health facilities to Indians, including through construction and renovation of hospitals, health centers, health stations, and other facilities. The section would specify the uses of funds and permits their use to match federal and other funds. The section would require the Secretary to promulgate regulations for application approval. It also would establish granting criteria, the grant selection process, and the requirements for technical assistance. In addition, under the demonstration projects, facilities would be allowed to provide services to otherwise ineligible persons—that is those who are not eligible for IHS services—and would extend hospital privileges in IHS facilities to non-IHS health practitioners. The section would require that equal criteria be used in evaluating tribal and IHS facilities, and would require integration of ISDEAA facility planning and construction into demonstration projects.

Section 308. Leases, Contracts and Other Agreements

This section would authorize the Secretary to enter into leases, contracts, or other agreements with ITs or TOs for the use of facilities owned or leased by ITs or TOs and used for the delivery of health services by an IHP. The section would authorize the leases to include provisions for construction or renovation and for compensation to ITs or TOs.

Section 309. Study on Loans, Loan Guarantees, and Loan Repayment

This section would require that the Secretary, in consultation with the Secretary of the Treasury and ITs and TOs, carry out a study to determine the feasibility of a loan or loan guarantee fund to provide ITs and TOs either direct loans or loan guarantees for the construction of health care facilities. The section would require the Secretary to make 10 specified determinations, such as the maximum principal amount and term of loans, amounts attributable for planning, appropriate security for loans, and legislative or regulatory changes needed. The section also would require the Secretary to submit a report to specified committees of Congress describing the consultations, the study results, and any recommendations.

Section 311. Indian Health Service/Tribal Facilities Joint Venture Program

This section would require the Secretary to establish joint venture demonstration projects with tribes and tribal organizations under which an IT or a TO would be required to expend funds, from tribal or non-tribal sources, to acquire or construct a health facility (including staff quarters) for at least 10 years, under a no-cost lease, in exchange for IHS agreement to provide staffing, equipment, and supplies for the operation and maintenance of the facility. The section would specify that tribes are eligible that have not begun, or have begun but not completed, the process of acquiring or constructing a facility. The provision would require the Secretary to determine, before entering into an agreement, whether the tribe or tribal organization meets criteria of need under either the criteria developed under IHCIA Section 301 or other criteria as determined under regulations. In addition, the section would require the Secretary to negotiate an agreement for the continued operation of the facility at the end of the 10-year lease. The section would also authorize recovery by tribes and organizations in a proportional amount from the United States for non-use or other breaches of the lease agreement within the 10-year agreement period. In

addition, the section would require that a IT or TO that breaches or terminates without cause such an agreement liable for United States amounts paid, and grant the Secretary specified rights of recovery.

Section 312. Location of Facilities

This section would require IHS and the BIA to give priority to locating facilities and projects on Indian lands, and on any lands in Alaska owned by an Alaska Native village, a village or regional corporation under the Alaska Native Claims Settlement Act,[31] or allotted to an Alaska Native, when developing or reorganizing IHS facilities or establishing related employment projects to address unemployment conditions in economically depressed areas, if requested by the Indian landowner and the IT with jurisdiction over the Indian lands. The section would require priority be given to tribally-owned lands and defines "Indian lands" as all lands within the limits of any Indian reservation and all trust or restricted lands over which a tribe exercises governmental power.

Section 313. Maintenance and Improvement of Health Care Facilities

This section would require the Secretary to submit to the President, for inclusion in an annual report to Congress, a report on the backlog of needed maintenance and repairs at IHS and tribal health care facilities, and on the renovation and expansion needs of existing facilities to support the growth of health care programs. The provision would limit the expenditure of IHS maintenance and improvement funds for newly constructed space to an IT's or TO's approved supportable space allocation (as defined through the health care facility priority system under IHCIA Section 301). The provision would authorize ITs, and TOs to use maintenance and improvement funds for renovation, modernization, and expansion, and for construction of replacement facilities if the costs of renovation would exceed a maximum renovation cost threshold, to be determined by the Secretary in consultation with ITs and TOs.

Section 314. Tribal Management of Federally Owned Quarters

This section would authorize THPs operating a health care facility and the associated federally-owned quarters pursuant to an ISDEAA contract or compact to establish reasonable rental rates for the federally-owned quarters, by notifying the Secretary, and to collect the rent directly. The section would set the objectives of the THP's rental rates, would require that such quarters remain eligible for improvement and repair funds to the same extent as federally-owned quarters, and would require at least 60 days' notice before changes in the rental rate. In addition, the section would specify requirements for direct rent collection by a THP, require federal employees subject to the rent to pay the THP directly, and set the effective date for a retrocession of rent collection authority. The provision would also allow rental rates in Alaska to be comparable to those in the nearest established community with a year-round population of 1,500.

[31] P.L. 92-203, act of Dec. 18, 1971, 85 Stat. 688, as amended; 43 U.S.C. 1601 et seq.

Section 315. Applicability of Buy American Act Requirement

This section would require application of the Buy American Act for all procurements made with funds appropriated under IHCIA Section 317 (authorizing appropriations for IHCIA Title III), but exempts ITs and TOs from the requirements of the Buy American Act. The section would also set a penalty for persons fraudulently affixing a "Made in America" label.

Section 316. Other Funding for Facilities

This section would authorize the Secretary to accept from any source, including federal and state agencies, funds available for the construction of health care facilities, to use such funds for the planning, design, and construction of Indian health facilities, and to place such funds in ISDEAA contracts and compacts. In addition, the section would authorize the Secretary to enter into interagency agreements with federal and state agencies or other entities, and to accept funds from such agencies, for the planning, design, and construction of health care facilities to be administered by an IHP. The section also would authorize any federal agency to which appropriations are made for health care facilities construction to transfer the funds to the Secretary for the construction of health care facilities to carry out the purposes of this act (i.e. to improve Indian health) and the purposes for which the funds were originally appropriated. The section would also require the Secretary to establish standards by regulation for the planning, design, and construction of health care facilities for Indians.

Access To Federal Health Services and Reimbursements

IHCIA Title IV in Section 3101(a) authorizes IHS health-care facilities to receive reimbursements from SSA's Medicare and Medicaid programs. This authorization was a major component of the original IHCIA passed in 1976. The title establishes a "special fund" to receive the reimbursements and would specify what they can be used for. It also authorizes THPs to elect to receive reimbursements directly, instead of through IHS. It excludes Medicare or Medicaid reimbursements from being considered when determining annual Indian health appropriations and would specify that IHS and THPs are the payer of last resort.

Sections 409, 410, 411, and 412 of IHCIA Title IV contain cross references to enacted SSA amendments that affect Indian health care. Specifically, the Children's Health Insurance Programs Reauthorization Act (P.L. 111-3)[32] and American Recovery and Reinvestment Act (ARRA, P.L. 111-5)[33] amended Medicaid and CHIP statutes as they apply to American Indians and Alaska Natives to require states to increase outreach, facilitate enrollment, and eliminate cost sharing for eligible American Indians and Alaska Natives in Medicaid and CHIP. These cross references are not included below.

In addition to amendments related to SSA programs, this title also includes sections related to private insurance and sections related to coordination between IHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD).

[32] CRS Report R40130, *The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker et al.

[33] CRS Report R40223, *American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5): Title V, Medicaid Provisions*, coordinated by Cliff Binder.

Section 401. Treatment of Payments under SSA Health Benefits Programs

This section would require that payments received by an IHP or an UIO from Medicare, Medicaid, or CHIP may not be considered in determining appropriations for Indian health care services. The section also would prohibit the Secretary from providing services to Indians with coverage under Medicare, Medicaid, or CHIP in preference to those Indians without such coverage. The section also would require that Medicare and Medicaid payments to IHS facilities be placed in a special fund to be held by the Secretary, and would require the Secretary to ensure that each IHS service unit receives 100% of the reimbursed amounts to which the service unit's facilities are entitled. The section would require that amounts in the special fund be used by a facility first (to the extent provided in appropriations acts) to improve IHS facilities so they can comply with the applicable conditions and requirements of Medicare or Medicaid; if the reimbursed amounts are in excess of the amount necessary to make such improvements, the facility would be required to use the funds, after consulting with the tribes being served by the service unit, to increase the facility's capacity to provide services or to increase the quality or accessibility of its services. The section would exclude THP electing to receive payments directly from Medicare or Medicaid from making payments into, or receiving from, the special fund.

The section would authorize THP to elect to directly bill and receive payments from Medicare, Medicaid, or CHIP. The section would require that payments be used for the same purposes as the special fund, and subject the payments to all auditing requirements applicable both to whichever programs it chooses to bill directly and to the IHP. The section would also require that a THP receiving reimbursements or payments under Medicare, Medicaid, or CHIP provide to IHS a list of each provider enrollment number (or other identifier) under which the THP receives such reimbursements or payments and requires that IHS share this and other necessary information with the Centers for Medicare and Medicaid Services (CMS), the agency that administers the Medicare, Medicaid, and CHIP programs. The section would direct the Secretary, with assistance from CMS, to examine and implement any administrative changes that would facilitate direct billing and reimbursement, including agreements with states necessary to provide for direct billing under Medicaid or CHIP. The section would allow participants (i.e. THPs) to withdraw from the program under the same conditions that a tribe or tribal organization may retrocede a contracted program under ISDEAA. In addition, the section would authorize the Secretary to terminate a direct billing participant if the Secretary determines the participant has failed to comply with certain specified requirements, but would require the Secretary to provide notice and an opportunity to correct the non-compliance. The section cross-references specified sections of the SSA relating to the special fund and the direct billing program (see Section 3201 below).

Section 402. SSA Health Benefit Programs Outreach and Enrollment Grants

This section would require the Secretary to make grants or enter into contracts with ITs and TOs for programs on or near reservations, trust lands, and Alaska Native villages, including using electronics and telecommunications, to assist individual Indians to enroll in Medicare, Medicaid, and CHIP, and pay premiums and cost sharing required by the programs.[34] Payment of premiums and cost sharing may be based on need as determined by the IT or TO. The section would also require the Secretary to place conditions as deemed necessary on the contracts and grants, including requirements to determine Indian Medicaid, Medicare, and CHIP populations, educate

[34] Section 508 of ARRA exempted American Indians and Alaska Natives from premiums and cost-sharing in Medicaid and CHIP.

Indians about the programs' benefits, provide transportation, and develop and implement methods to improve Indian participation in the programs. The section would also apply the enrollment, premium, and cost-sharing assistance program to UIOs for the populations they serve, and set requirements for agreements with such organizations. The section would also require the Secretary, acting through CMS, to consult with states, IHS, ITs, TOs, and UIOs on developing and disseminating best practices to facilitate agreements between the states, ITs, TOs, and UIOs regarding enrollment and retention of Indians in Medicare, Medicaid, and CHIP. The section cross-references SSA Section 1139 regarding agreements for collecting, preparing, and submitting applications for Medicaid and CHIP. The section also defines the terms "premium," "cost sharing," and "benefits."

Section 403. Third Parties Reimbursements

This section would permit the United States, ITs, and TOs the right to recover reasonable charges incurred (or, if higher, the highest amount a third party would pay for care and services from a non-governmental provider), for health services provided by these entities to an individual, to the same extent that the individual or any nongovernmental provider of health services would be eligible to receive reimbursement or indemnification. The section would specify that entities from whom recovery can occur include insurance companies, health maintenance organizations, employee benefit plans, third-party tortfeasors, state political subdivisions, local governments, or any other responsible or liable third parties. The section would limit the right of recovery against any state to circumstances where the health services are covered under workers' compensation laws or a no-fault automobile accident insurance plan. The section would prohibit state or local laws, contract provisions, insurance or health maintenance organization policies, employee benefit plans, self-insurance plans, managed care plans, or other health care plans or programs entered into or renewed after November 23, 1988, from preventing or hindering the right of recovery. The section also would prohibit any action by the U.S, an IT, or TO from affecting the right of an injured person to collect for the portion of their damages not covered hereunder. The section would permit the United States, an IT, or a TO to enforce the right of recovery by intervening or joining in specified civil actions or proceedings, or by instituting a separate civil action (after notifying the individual or his representatives or heirs), and require reasonable efforts to notify the individual. The section also would authorize ITs or TOs, independent of the rights of the injured or diseased person, to recover from tortfeasors or their insurers the reasonable value of health services provided or paid in accordance with the Federal Medical Care Recovery Act.

The section would prohibit U.S. recovery from an IT's or TO's, or UIO's self-insurance plan, but allows recovery from a tribe if the tribal governing body provides specific written authorization for a specified time period and allow expenditure of amounts recovered to provide additional health services. The section would require award of reasonable attorneys fees and costs of litigation to prevailing plaintiffs under this section, would prohibit specified health insurance and related entities from denying reimbursement of an IHS or IT's or TO's claim on the basis of the claim's format (if the format meets certain standards), and applies a specified statute of limitations.[35] The section would apply to UIOs the same rights of recovery, for the populations they serve, as the rights allowed to ITs and TOs for their populations served. The section would

[35] 28 U.S.C. 2415

provide that nothing in this section limits the right of the United States, an IT, or a TO to recover under any applicable federal, state, or tribal law, including medical lien laws.

Section 404. Crediting of Reimbursements

This section would require that—except as provided under IHCIA Section 202[36] regarding the CHEF or under IHCIA Section 806 regarding services to ineligible persons—all reimbursements received or recovered for provision of health service by IHS, an IT, a TO, or a UIO, would be required to be credited to the respective entity (including the service unit providing the health service). The section would require that reimbursements be used as specified under IHCIA Section 401. The section would also prohibit IHS from offsetting or limiting the amounts obligated to any service unit, or any entity receiving IHS funding, because of the receipt of reimbursements under this section.

Section 405. Purchasing Health Care Coverage

This section would authorize ITs, TOs, or UIOs to use funds made available for health benefits for IHS beneficiaries under SSA programs and the ISDEAA (except for funds under IHCIA Section 402) to purchase health benefits coverage that qualifies as creditable coverage under PHSA Section 2701 through a tribally owned and operated health care plan, a state or locally authorized or licensed health care plan, a health insurance provider or managed care organization, or a self-insured plan. The section would exclude specified types of coverage from eligibility, namely, health flexible spending plans under IRC Section 106 and high deductible health plans as defined in IRC Section 223. The section would permit that the coverage purchased may be based on the financial needs of the individual beneficiaries (as determined by the tribes being served) and would allow the use of funds for the expenses of operating a self-insured plan.

Section 406. Sharing Arrangements with Federal Agencies

This section would authorize the Secretary to enter or expand arrangements for IHS, tribes, and tribal organizations to share medical facilities and services with the VA and the DOD, but require consultation with affected tribes prior to finalizing an arrangement. The section would prohibit the Secretary from taking any action under this section that would impair (1) an Indian's priority access to, or eligibility for, health care services provided through IHS, (2) a veteran's priority access to VA health care services, (3) the quality of IHS health care provided to an Indian, (4) the quality of VA or DOD health care, or (5) an Indian veteran's eligibility to receive VA health care. The section would require reimbursement to the IHS, ITs, or TOs by the VA or DOD where beneficiaries eligible for VA or DOD services receive care from the IHS, ITs, or TOs. The section would prohibit construing the section as creating any right of a non-Indian veteran to IHS health services.

Section 407. Eligible Indian Veteran Services

This section would make a Congressional findings that collaborations between the Secretary and the VA for treatment of Indian veterans at IHS facilities, and increased enrollment for VA services

[36] The bill specifies Section 202; however, it is likely referring to Section 226.

by Indian tribal veterans, should both be encouraged to the maximum extent practicable, and reaffirms the goals of a 2003 memorandum of understanding between IHS and VA's Veterans Health Administration regarding VA-authorized treatment of eligible Indian veterans at IHS facilities. The section would require the HHS Secretary to provide for payment for veteran-related, VA-authorized treatment under a local memorandum of understanding. The section would require the HHS Secretary to establish guidelines for such payments to the VA, and prohibits use of funds appropriated for IHS facilities, CHS, or contract support costs to make such payments. The section would require the HHS Secretary to consult with affected tribes in negotiating local memoranda of understanding, and define "eligible Indian veteran" and "local memorandum of understanding."

Section 408. Payor of Last Resort

This section would specify that IHPs and health care programs operated by UIOs would be the payor of last resort for services provided to eligible persons.

Section 413. Navajo Nation Medicaid Agency Feasibility Study

This section would require the Secretary to conduct a study to determine the feasibility of treating the Navajo Nation[37] as a state for Medicaid purposes, for Indians living within the Navajo Nation's boundaries. The provision would require the Secretary to consider the feasibility of certain options and to report the results of the study to specified committees of Congress not later than three years after enactment of this act.

Health Services for Urban Indians

IHCIA Title V of Section 3101(a) directs the HHS Secretary to make contracts with or grants to UIOs for health projects to serve urban Indians. The purpose of this program is to make IHS more accessible and available to urban Indians. Such grants or contracts are under the authority of the Snyder Act, not the ISDEAA.

There are 34 UIHPs. UIHPs may serve a wider range of eligible persons than the general IHS health care programs, such as members of terminated or state-recognized tribes and their children and grandchildren. These 34 UIHPs operate at 41 locations, with different programs offering different services, such as ambulatory health care, health promotion and education, immunizations, case management, child abuse prevention and treatment, and behavioral health services.[38] Besides IHS grants and contracts, UIHPs receive funding from state and private sources, patient fees,[39] Medicaid, Medicare, and other non-IHS federal programs.[40]

[37] The Navajo reservation is located in parts of Arizona, Utah, and New Mexico.

[38] U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, *Indian Health Service: Fiscal Year 2010 Justification of Estimates for Appropriations Committees* (Rockville, MD: HHS/PHS/IHS, 2009), p. CJ-133; http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/documents/IHS_CJ_2010_Final_Submission.pdf

[39] IHS is forbidden to bill or charge Indians (see 25 U.S.C. 1681 and 25 USC 458aaa-14), but IHCIA Title V does not prohibit UIHPs from charging their patients.

[40] IHS, Office of Urban Indian Health Programs, *Urban Indian Health Program Statistics, FY2005* ([Rockville, MD]: IHS, October 16, 2007), p. 4.

IHCIA Title V sets the requirements for the contracts and grants, and would expand the program by authorizing residential treatment centers for urban Indian youth, grants for diabetes prevention and treatment, and use of the Community Health Representatives program (see IHCIA Title I).

Section 502. Contracts With, and Grants To, Urban Indian Organizations

This section would require the Secretary, under authority of the Snyder Act, to enter contracts with or make grants to UIOs to establish in urban centers programs that meet this IHCIA's requirements. The section would require the Secretary, subject to IHCIA Section 506, to include in the contracts and grants such conditions as necessary.

Section 503. Contracts and Grants for Health Care and Referral Services

This section would include the requirements that the Secretary is subject to when making grants or contracts to UIOs for health care services. The section would specify that contracts require UIOs to estimate the population, health care needs and status of the urban Indians, provide basic health education, make recommendations to federal, state, local, and other agencies for improving health programs, and where necessary provide health care services for urban Indians directly or through contracts. The section would also require the Secretary to prescribe selection criteria by regulation and require inclusion of seven specified criteria, including the urban Indians' unmet health needs, extent of duplication of services already provided by health projects funded other than by this title, and the UIO's capability to perform the contract requirements. The section would also require the Secretary, through the contracts and grants, to facilitate access to services for health promotion and disease prevention, immunization, behavioral health, and child abuse treatment and prevention. The section would also authorize the Secretary to contract with an UIO to provide health services in more than one urban center.

Section 504. Use of Federal Government Facilities and Sources of Supply

This section would authorize the Secretary to (1) permit UIOs carrying out contracts or grants under this title to use existing HHS facilities and equipment, (2) donate excess IHS or General Services Administration real or personal property to such organizations, or (3) acquire excess or surplus federal government real or personal property for donation to such organizations (subject to a priority for tribes and tribal organizations). The section would permit UIOs carrying out contracts or grants under this title to be deemed to be federal executive agencies under Section 201 of the Federal Property and Administrative Services Act of 1949, with access to federal prime vendors, when the organizations are carrying out IHCIA Title V contracts or grants.

Section 505. Contracts and Grants to Determine Unmet Health Care Needs

This section would authorize the Secretary, under authority of the Snyder Act, to enter into contracts with or make grants to UIOs in urban centers without contracts or grants under IHCIA Section 503. Under these contracts/grants, the UIOs would determine health status and unmet health care needs of the Indians in such urban centers and related information to help the Secretary determine whether to enter into a contract with or make a grant, under Section 503, to the UIO to provide services. The section would also prohibit the renewal of grants or contract made under this section.

Section 506. Evaluations and Renewals

This section would require the Secretary to develop procedures to evaluate UIO compliance with and performance of contracts and grants. These procedures would be required to include either annual onsite evaluations or evidence of the UIO's accreditation by a recognized Medicare review entity. The section would authorize non-renewal of contracts and grants and would require the Secretary, if an evaluation reveals noncompliance with or non-performance of a grant or contract, to attempt to resolve the area of noncompliance or nonperformance before renewing the contract or grant. The section would also require the Secretary, before renewing the IHCIA Section 503 contract or grant of an organization that has completed a IHCIA Section 504 contract or grant, to review an organization's records, the onsite evaluations or accreditations, and reports under IHCIA Section 507.

Section 507. Other Contract and Grant Requirements

This section would require that contracts with UIOs be in accordance with federal contracting laws and regulations relating to procurement, except that the section allows, at the Secretary's discretion, contract negotiation without advertising as well as exemptions from specified federal laws on contracts for federal buildings and works and on the sale of unneeded federal facilities to states. The provision would authorize lump-sum advance payments (with a deadline) unless the Secretary determines the UIO is not capable of administering such a payment; would authorize semi-annual or quarterly payments or reimbursements to organizations without such capability; and would require carrying forward unexpended payments. The section also would authorize revision of contracts, if requested, and would require fair and uniform provision of services to urban Indians.

Section 508. Reports and Records

This section would require urban Indian contractors and grantees under this title to submit semi-annual reports to the Secretary containing specified information, including a minimum set of data using uniform elements (specified by the Secretary after consultation with UIOs). The section would make the contractors' and grantees' records subject to audit by the Secretary or GAO, and would allow the cost of an annual outside audit by a certified public accountant or firm as a cost of a contract or grant. The section would also require the Secretary, in consultation with UIOs, to submit a report to Congress by 18 months after enactment on urban Indians' health status, services provided under this title, and unmet health needs, and would permit the Secretary to contract with a national organization representing UIOs to conduct any aspect of the report.

Section 510. Facilities

This section would authorize the Secretary to make funds available to contractors or grantees for leasing, purchasing, renovating, constructing, and expanding facilities, including leased facilities, to comply with applicable licensure or certification requirements. The section would authorize the Secretary to conduct a study of the feasibility of a loan fund for direct loans or loan guarantees to UIOs for construction of health care facilities.

Section 511. Division of Urban Indian Health

This section would establish a Division of Urban Health Programs within IHS responsible for carrying out IHCIA Title V and overseeing the programs and services authorized.

Section 512. Grants for Alcohol and Substance Abuse-Related Services

This section would authorize the Secretary to make grants to urban Indian contractors and grantees for the provision of alcohol and substance abuse services in urban centers, and would require the Secretary to establish criteria for alcohol and substance abuse grants and to develop a grant allocation methodology based on the criteria.

Section 515. Conferring with Urban Indian Organizations

This section would require the Secretary to ensure that IHS confers or conferences with UIOs to the greatest extent practicable. It would define "confer" and "conference."

Section 516. Urban Youth Treatment Center Demonstration

This section would require the Secretary to fund construction and operation of at least one residential youth treatment center in each IHS Area meeting certain requirements to demonstrate provision of alcohol and substance abuse treatment services for urban Indian youth in a culturally competent residential setting. The section would require that such residential treatment centers be in addition to facilities constructed under IHCIA Section 707. This section would also require that, for a facility to be constructed, the IHS Area must include a UIO, have urban Indian youth who need alcohol and substance abuse treatment in a residential setting, and have a significant shortage of culturally competent residential treatment services.

Section 517. Grants for Diabetes Prevention, Treatment and Control

This section would authorize the Secretary to make grants to urban Indian contractors or grantees for diabetes prevention, treatment, and control. The section would specify goals for each grant and would require the Secretary to establish criteria for the grants, including the size and location of the urban Indian population served, the population's need for diabetes prevention, treatment, and control, the organization's performance standards and capability, and its willingness to collaborate with the diabetes patient registry, if any, established by the Secretary in the IHS Area under IHCIA Section 203(e).

Section 518. Community Health Representatives

This section would authorize the Secretary to contract with or make grants to urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under IHCIA Section 109.

Section 521. Authorization of Appropriations

Besides authorizing appropriations, this section would authorizes the Secretary to establish programs, including grants, for UIOs that are identical to programs established pursuant to IHCIA

Section 126 (behavioral health training), Section 209 (school health education), Section 211 (prevention of communicable diseases), Section 701 (behavioral health prevention and treatment services), and Section 707(g) (youth multidrug abuse program).

Section 522. Health Information Technology

This section would authorize the Secretary to make grants to UIOs under this title for the development, adoption, and implementation of health information technology (HIT) (as defined in Section 3000(5) of ARRA),[41] telemedicine services development, and related infrastructure.

Organizational Improvements

IHCIA Title VI of Section 3101(a) would establish IHS's organizational position. Under current law, IHS is part of the PHS within HHS, and is administered by a director as established by IHCIA Section 601. The sections below replace the IHS director with the new position of Assistant Secretary of Indian Health. IHCIA Title VI would also authorize contracts and agreements for enhancing information technology and systems.

Section 601. Establishment of IHS as a PHS Agency

This section would establish IHS within the PHS and establishes the position of Assistant Secretary for Indian Health, to be appointed by the President and confirmed by the Senate, with a term of four years. The section would specify the Assistant Secretary's duties and responsibilities, including managing funds, entering contracts, carrying out all functions relating to the management of hospitals and facilities and all IHPs under specified acts, reporting to the Secretary on Indian health policy and budget matters, interacting with other assistant secretaries and agency heads on Indian health, and coordinating department activities on Indian health. The section also would apply Indian preference under Section 12 of the Indian Reorganization Act[42] to IHS personnel actions for new positions resulting from its establishment under this section. The section would deem any reference to the IHS director in federal laws, regulations, executive orders, rules, or delegations of authority, or in documents relating to the director, to be a reference to the Assistant Secretary.

Section 602. Automated Management Information System

This section would require the Secretary to establish automated management information systems for IHS and for each THP, and sets requirements for the systems, including privacy regulations under HIPAA. The section would require that patients, pursuant to HIPAA, have access to their own health records held by or for IHS. The section would authorize the Secretary to enter into contracts, agreements, or joint ventures with other federal agencies, states, and private and nonprofit organizations to enhance information technology in IHPs.

[41] P.L. 111-5, act of Feb. 17, 2009, 123 Stat. 115, 228; 42 USC 300jj.

[42] P.L. 73-383, act of June 18, 1934, §12, 48 Stat. 984, 986; 25 U.S.C. 472.

Behavioral Health Programs

IHCIA Title VII of Section 3101(a) covers behavioral health care programs. Under current law, Title VII authorizes only alcohol and substance abuse programs; this bill would expand the program to cover all mental and behavioral health programs, to create a "comprehensive behavioral health prevention and treatment program" providing a "continuum of behavioral health care" (see IHCIA Sections 701 and 703 of Section 3101(a)). IHCIA Title VII would define a number of terms related to behavioral health care.

Section 701. Behavioral Health Prevention and Treatment Services

This section would include the purpose of the title, which includes directing the Secretary, acting through IHS, to develop a comprehensive behavioral health care program that emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. The section would require the Secretary to encourage ITs, TOs, and UIOs to develop tribal, local, and area-wide plans for Indian behavioral health services, to include assessments of specified behavioral problems, the number of Indians affected, the financial and human costs, the existing and necessary resources to prevent and treat such problems, and an estimate of necessary funding. The section would require the Secretary to coordinate with existing national clearinghouses to include such plans and any reports on their outcomes, ensure access to the plans and outcomes by IHS, tribes, and tribal and urban Indian organizations, and provide technical assistance in the development of these plans and related standards of care. The section also would require the Secretary to provide, through IHS, and to the extent feasible and funded, a comprehensive continuum of behavioral health care that includes nine specified services, including acute hospitalization, detoxification, and emergency shelter, as well as specified services for Indian children, adults, families, and elders. The section would authorize ITs, TOs and UIOs to establish community behavioral health plans, would require IHS and BIA cooperation and assistance in developing and implementing such plans, and would authorize grants to ITs and TOs for technical assistance and administrative support for such plans. The section would require the Secretary, through IHS, ITs, TOs, and UIOs, to coordinate behavioral health planning with other federal and state agencies. The section would also require the Secretary, within one year of enactment, to assess the need, availability, and cost for inpatient mental health care and facilities for Indians, including possible conversion of existing, underused IHS hospital beds into psychiatric units.

Section 702. Memoranda of Agreement with the Department of the Interior

This section would require the Secretary and the Secretary of the Interior, not later than 12 months after enactment, to develop and enter into memoranda of agreement, or update memoranda of agreement required by Section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act,[43] covering eight specified activities, including a comprehensive assessment and coordination of mental health care needs and services available or unavailable to Indians, the ensuring and protection of Indians' right of access to general mental health services, and annual reviews of the agreement to be provided to Congress and tribes and tribal organizations. The section would require that the memoranda include provisions assigning to IHS responsibility for determining the scope of alcohol and substance abuse problems among Indians, assessing existing and needed resources, and estimating necessary funding. The section also

[43] P.L. 99-570, Title IV, subtitle C, act of Oct. 27, 1986, 100 Stat. 3207-137, as amended; 25 U.S.C. 2401 et seq.

would require that each memorandum, renewal, or modification be published in the Federal Register, with copies to ITs, TOs, and UIOs.

Section 703. Behavioral Health Prevention and Treatment Program

This section would require the Secretary to provide through IHS a program of comprehensive behavioral health, prevention, treatment, and aftercare, including "Systems of Care,"(as defined in IHCIA Section 716) for Indian tribal members, and requires that the comprehensive program include prevention, education, specified treatments, rehabilitation, training, and diagnostic services. The section would authorize the Secretary, through IHS, to provide the services through contracts with public and private behavioral health providers, and would require the Secretary to assist tribes and tribal organizations to develop criteria for certification of providers and accreditation of facilities.

Section 704. Mental Health Technician Program

This section would require the Secretary, under the Snyder Act, to establish within IHS a mental health technician training and employment program for Indians. The section also would require the Secretary, through IHS, to provide high-standard paraprofessional training in mental health care, to supervise and evaluate these technicians, and to ensure that the program includes using and promoting traditional Indian health care practices of the tribes served.

Section 705. Licensing Requirement for Mental Health Care Workers

This section would require that, subject to IHCIA Section 221 (regarding licensing), any person employed as a psychologist, social worker, or marriage and family therapist to provide mental health care services to Indians in a clinic be licensed to provide the specified service. The section would provide that a trainee in psychology, social work, or marriage and family therapy may provide mental health care services if the trainee is directly supervised by someone licensed in the specified service, is enrolled in or has completed at least two years of course work in an accredited post-secondary education program for the specified service, and meet other requirements that the Secretary may establish.

Section 706. Indian Women Treatment Programs

This section would authorize the Secretary, consistent with IHCIA Section 701, to make grants to ITs, TOs, and UIOs to develop and implement a comprehensive behavioral health program for prevention, intervention, treatment, and relapse prevention that specifically addresses the cultural, historical, social, and childcare needs of Indian women. The section would specify uses of the grants, including community training and education, counseling, support, and development of prevention and intervention models. The section also would require the Secretary, in consultation with ITs and TOs, to establish grant approval criteria, and to allocate 20% of the program's funds for grants to UIOs.

Section 707. Indian Youth Program

This section would establish a number of Indian youth behavioral health programs. The section would require the Secretary, consistent with IHCIA Section 701, to develop and implement a

program for acute detoxification and treatment for Indian youth, including behavioral health services, regional treatment centers with detoxification and rehabilitation services, and local programs developed by tribes or tribal organizations under ISDEAA. The section would require the Secretary, through IHS, to construct, renovate, or purchase, and staff and operate (under the Snyder Act) at least one youth regional treatment center or treatment network in each IHS area (treating the California Area as two areas), in a location agreed upon by a majority of the area's tribes; the section also would authorize funding to two specified Alaska Native entities for youth treatment facilities in Alaska. The section would authorize the Secretary to provide intermediate behavioral health services for Indian children and adolescents, and would specify that such services include pretreatment assistance, inpatient, outpatient, and aftercare services, emergency care, suicide prevention, and prevention and treatment of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence. The section would set the allowable uses of funds for intermediate behavioral health services, and requires the Secretary, in consultation with ITs and TOs, to develop grant approval criteria.

The section also would require the Secretary, in consultation with ITs and TOs, to identify and use suitable federally-owned structures for local residential or regional behavioral health treatment for Indian youths, and establish suitability guidelines. The section allows use of any such federally-owned structure under terms agreed upon by the Secretary, the responsible federal agency, and the IT or TO operating the program. The section also would require the Secretary, ITs, and TOs, in cooperation with the Interior Secretary, to develop local community-based rehabilitation and aftercare services in each IHS service unit for Indian youths with significant behavioral health problems, including long-term treatment, community reintegration, and monitoring, to be provided by trained staff. The section would require the Secretary, in providing services under this section, to provide for inclusion of family in such services, and would specify that not less than 10% of funds for the local rehabilitation and aftercare services program would be permitted to be used for outpatient care of adult family members of an Indian youth in the program. The section also would require the Secretary, through IHS, to provide programs and services to prevent and treat multi-drug abuse among Indian youths in Indian communities, on or near reservations, and in urban areas, and provide appropriate mental health services. The section would require the Secretary to collect data on specified aspects of Indian youth mental health for the report under IHCIA Section 801.

Section 708. Indian Youth Telemental Health Demonstration Project

This section would authorize the Secretary to carry out a demonstration project by making four-year grants to not more than five tribes and tribal organizations with telehealth capabilities to use for telemental health services in youth suicide prevention and treatment. The section would define terms and would direct the Secretary to give priority to ITs and TOs that serve tribal communities that have a demonstrated need or are isolated and have limited access to mental health services, or that enter into collaborative partnerships to provide the services, or that operate a detention facility where youth are detained. The section would describe the uses of the grants, including the use of telemedicine for psychotherapy, psychiatric assessments, and diagnostic interviews of Indian youth; the provision of clinical expertise and other medical advice to frontline health care providers working with Indian youth; training and related support for community leaders, family members, and health and education workers who work with Indian youth; the development of culturally relevant educational materials on suicide prevention and intervention; data collection and reporting; and the use of the tribe's traditional health care practices. The section would include requirements for grant applications, encourages collaboration among grantees and grantee reports to the national clearinghouse under IHCIA Section 701, and would require grantees to

submit annual reports to the Secretary. In addition, the section would require the Secretary to submit a report to specified committees of Congress no later than 270 days after termination of the demonstration project. The report would include evaluations of whether the project should be made permanent or expanded to more than five grants and to UIOs. The section would authorize appropriations of such sums as may be necessary to carry out this section.

Section 709. Mental Health Facilities Design, Construction, and Staffing

This section would authorize the Secretary, through IHS, to provide in each IHS area, not less than one year after enactment, at least one inpatient mental health facility for Indians with behavioral health problems. The section would require that California be considered two areas and would require the Secretary to consider the conversion of existing underused IHS hospital beds into psychiatric units to meet the need for such facilities.

Section 710. Training and Community Education

This section would require the Secretary, in cooperation with the Interior Secretary, develop and implement in each IHS service unit or tribal program a program of community education and involvement for specified tribal community leaders in behavioral health issues, possibly including community-based training, or assist tribes and tribal organizations to do so. The section also would require the Secretary to provide specified instruction in behavioral health issues to appropriate IHS and BIA employees and personnel in contracted IHS and BIA programs and schools.[44] In addition, this section would require the Secretary, as part of the community education and employee instruction programs, to develop and provide community-based training models addressing specified aspects of behavioral health problems, in consultation with ITs, TOs, and Indian alcohol and substance abuse prevention experts.

Section 711. Behavioral Health Program

This section would authorize the Secretary, through IHS, to develop and implement programs to deliver innovative community-based behavioral health services to Indians, and authorizes grants to tribes and tribal organizations for such programs. The section would specify criteria for awarding such grants, and would require the Secretary to use the same criteria in evaluating all project applications.

Section 712. Fetal Alcohol Disorder Programs

This section would authorize the Secretary, through IHS, to develop and implement fetal alcohol disorder (FAD) programs (as defined in IHCIA Section 4), consistent with IHCIA Section 701, and to establish criteria for approval of funding applications. The section would specify grant uses, including developing and providing services for the prevention, intervention, treatment, and aftercare for those affected by FAD, early childhood intervention projects, supportive services, and housing. The section also would require the Secretary, through IHS, to provide FAD prevention, treatment, and aftercare services as well as specified support services; would require

[44] The BIA's educational programs were transferred to a new agency, the Bureau of Indian Education (BIE), in 2006.

the Secretary to establish a Fetal Alcohol Disorder Task Force for advice on providing these services; and would specify the membership of the Task Force.

The section would require the Secretary to make grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) in HHS to ITs, TOs, and UIOs for applied research projects to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and aftercare for Indians affected by fetal alcohol spectrum disorders. The section would require that 10% of appropriations under this section be used for grants to UIOs funded under IHCIA Title V.

Section 713. Child Sexual Abuse and Prevention Treatment Programs[45]

This section would require the Secretary, through IHS, and consistent with IHCIA Section 701, to establish in every IHS Area treatment programs for child victims of sexual abuse and perpetrators of child sexual abuse who are Indians or members of Indian households. The provision would specify five uses of funding, including developing community education, identifying and providing treatment to victims, developing culturally-sensitive prevention models and diagnostic tools, and providing treatment to perpetrators. The section would require that the programs be carried out in coordination with programs and services authorized under the Indian Child Protection and Family Violence Prevention Act.[46]

Section 714. Domestic and Sexual Violence Prevention and Treatment

This section would authorize the Secretary to establish programs in each IHS Area to prevent and treat Indian victims and perpetrators of domestic violence or sexual violence. The section would require program funds be used for prevention and community education programs, behavioral health services and medical treatment for victims (including examinations by sexual assault nurse examiners), rape kits, development of prevention and intervention models (including traditional health care), and identification and treatment of Indian perpetrators. The section would require the Secretary to establish protocols, policies, procedures, standards, training curricula, and training and certification requirements for victim services within one year of enactment, and requires a report on these activities to specified committees of Congress within 18 months of enactment. The section also would require the Secretary, in coordination with the Attorney General, federal and tribal law enforcement agencies, IHPs, and victim organizations, to develop victim services and victim advocate training programs, for specified purposes; and requires the Secretary to report to specified committees of Congress on such services and programs, including improvements, obstacles, costs needed to address the obstacles, and any recommendations.

Section 715. Behavioral Health Research

This section would require the Secretary, in consultation with appropriate federal agencies, to make contracts with or grants to ITs, TOs and UIOs, and appropriate institutions for research on the incidence and prevalence of behavioral health problems among Indians served by IHS, ITs, or TOs and in urban areas. The section would direct that research priorities include the multifactorial causes of Indian youth suicide; the interrelationship of behavioral health problems with

[45] Section 713's title may be intended to read, "Child Sexual Abuse Prevention and Treatment Programs."

[46] P.L. 101-630, Title IV, act of Nov. 28, 1990, 104 Stat. 4544, as amended; 25 U.S.C. 3202 et seq., 18 U.S.C. 1169.

alcoholism, suicide, homicide, and family violence, especially on children; and the development of models of prevention techniques, especially as regards children.

Miscellaneous

IHCIA Title VIII of Section 3101(a) includes a number of separate provisions covering reports, regulations, abortion, certain persons' eligibility for IHS services, criminal jurisdiction of a tribally operated hospital in Oklahoma, and a variety of other topics.

Section 801. Reports

This section would require the Secretary to submit to Congress each fiscal year a report containing 23 specified reports, including 18 reports required under other IHCIA sections. Among the proposed topics of specified reports are the progress made in meeting health objectives, impacts of new national programs, Indian use of health services including CHS, funding requested under IHCIA Section 201, infectious diseases, health care and sanitation facilities status, maintenance and repair backlogs, program evaluations, effects of the movement of patients between IHS service units, and the extent of compliance with IHS credentialing and state licensing requirements.

Section 802. Regulations

This section would require the Secretary, within 90 days of enactment, to initiate negotiated rulemaking for regulations to carry out IHCIA, except for specified sections for which rulemaking under the Administrative Procedures Act[47] is authorized. The section would establish a deadline of two years after enactment for the Secretary to publish proposed regulations in the Federal Register, with a minimum comment period of 120 days, and would establish a deadline of three years after enactment to publish final regulations. The section would require that any negotiated rule-making committee under this section consist only of representatives of ITs, TOs, and the federal government, and would require the Secretary to adapt negotiated rulemaking to the context of self-governance and the government-to-government relationship. The section would prohibit lack of regulations from limiting the effect of IHCIA.

Section 803. Plan of Implementation

This section would require the Secretary, not less than one year after enactment, and in consultation with ITs, TOs, and UIOs, to submit to Congress a plan detailing by title and section how IHCIA would be implemented. The section would specify that lack of such a plan would not limit the effect, or prevent the implementation, of IHCIA.

Section 804. Limitation on Use of Funds Appropriated to Indian Health Service

This section would provide that any limitation contained in HHS appropriations on the use of federal funds for abortions would be required to apply for that period with respect to funds appropriated for IHS.

[47] 5 U.S.C., Chap. 5, subchap. II, and Chap. 7.

Section 805. Eligibility of California Indians

This section would make specified California Indians eligible for IHS health services, including members of federally-recognized tribes, descendants of Indians residing in California as of June 1, 1852 (if they are members of a community served by a local IHS program and regarded as Indian), Indians holding trust interests in certain types of land allotments in California, and Indians (and their descendants) listed on the plans for asset distribution in California under the act of August 18, 1958[48] (terminating federal recognition of certain California tribes). The section would prohibit construing anything in the section as expanding California Indians' eligibility for IHS health services beyond their eligibility as of May 1, 1986.

Section 806. Health Services for Ineligible Persons

This section would authorize IHS health services for certain ineligible persons who are children or (if the governing body of the tribe or tribal organization agrees) spouses of eligible Indians. For otherwise ineligible persons (who are not children or spouses) who reside in an IHS service unit's service area, at IHS-operated programs, the section would authorize the Secretary to provide health services, if requested by the tribes served and if the Secretary and the tribes determine that provision of such services will not result in denial or diminution of health services to eligible Indians and that there are no reasonable alternative health facilities or services in or outside the service unit. For otherwise ineligible persons (not children or spouses) at health facilities operated by ITs or TOs under ISDEAA contracts and compacts, the section would authorize the governing body of such ITs or TOs to determine whether to provide services to such ineligible persons. The section would require reimbursement from otherwise ineligible persons of not less than the actual costs for IHS-provided health services; direct that reimbursements, including under Medicare, Medicaid, or CHIP, be credited to the facility providing the service for the purposes listed in IHCIA Section 401; and would authorize the Secretary to provide health services through IHS for indigent persons not otherwise eligible, but only if the state or local government agrees to reimburse IHS for the expenses it incurs. The section would provide that tribes may revoke their consent to provision of health services to any otherwise ineligible persons (not children or spouses). The section also would authorize IHS to provide health services to otherwise ineligible persons to achieve stability in a medical emergency, prevent the spread of a communicable disease, deal with a public health hazard, provide care to a non-Indian woman pregnant with an eligible Indian's child, or provide care to immediate family members if such care is directly related to the treatment of an eligible individual. The section would authorize extending hospital privileges to non-IHS health care practitioners who provide services to certain ineligible persons, and also permit such practitioners to be designated as federal employees for the purposes of the Federal Tort Claims Act,[49] but only while providing services to eligible individuals under the conditions under which such hospital privileges are extended.

Section 807. Reallocation of Base Services

This section would prohibit any allocation of IHS funding in a fiscal year that reduces an IHS service unit's recurring programs, projects, or activities by 5% or more from the previous fiscal year unless the Secretary has submitted to Congress a report on the proposed change, the reasons

[48] P.L. 85-671, act of Aug. 18, 1958, 72 Stat. 619, as amended.

[49] P.L. 79-601, act of Aug. 2, 1946, Title IV, 60 Stat. 842, as amended; 28 U.S.C., Chap. 171.

for the change, and the likely effects. The section exempts the section from applying if total IHS appropriations for a fiscal year are at least 5% less than the previous fiscal year.

Section 809. Moratorium

This section would make permanent language that has been repeated in annual IHS appropriations acts since FY1989.[50] Specifically, this section would require IHS to provide services according to eligibility criteria effective September 15, 1987, subject to IHCIA Sections 805 and 806, until enactment of specified appropriations to pay for increased costs of new eligibility criteria issued under a final rule that was published in the Federal Register on September 16, 1987.

Section 812. Use of Patient Safety Organizations

This section would authorize IHS, an IT, or a TO, or a UIO to use a patient safety organization to provide for quality assurance activities, in accordance with PHSA Title IX.

Section 813. Medical Quality Assurance Records Confidentiality

This section would make medical quality assurance records created by an IHP or a UIHP confidential and privileged, and prohibit their disclosure except to specified entities for specified purposes. The section would exempt such records from the Freedom of Information Act,[51] require the Secretary to promulgate regulations, and define terms.

Section 817. Authorization of Appropriations; Availability

In addition to appropriations, this section would subject new spending authority (as described in Section 401 of the Congressional Budget Act of 1974[52] provided under IHCIA to the availability of appropriations. The section also makes funds appropriated under IHCIA available until expended.

Other Sections of Title I of Division D

The provisions in subsections 3101(b)-(c) of Title I make technical corrections in other federal laws, including Executive Schedule pay laws, necessitated by IHCIA Section 601's creation of a new Assistant Secretary for Indian Health. The other sections of Division D (Sections 3102 and 3103) authorize the establishment of a new foundation and require a GAO report.

[50] P.L. 100-446, act of Sept. 27, 1988, 102 Stat. 1774, 1817. Section 315 of the continuing appropriations act for FY1988 (P.L. 100-202, act of Dec. 22, 1987, 101 Stat. 1329, 1329-254 – 1329-255) had delayed implementation of the final rule until Sept. 16, 1988.

[51] 5 U.S.C. 552

[52] 2 U.S.C. 651

Section 3102. Native American Health and Wellness Foundation

This section would amend ISDEAA by adding a new title, Title VIII, Native American Health and Wellness Foundation(Foundation). This new title would direct the Secretary to establish the Foundation and a committee to assist in establishing the Foundation, and would specify that the Foundation's duties would be to encourage, accept, and administer private gifts of property and income for the benefit of, or in support of, the mission of IHS; to undertake activities that will further the health and wellness activities and opportunities of Native Americans; and to participate with and assist federal, state, and tribal governments, agencies, entities, and individuals in such undertaking. The new title would establish the Foundation's powers, Board of Governors, and officers, and make the existence of the Foundation perpetual. The new title would also define terms, limits administrative costs, requires audits, authorizes appropriations of $500,000 for each fiscal year (to be adjusted to reflect changes in the Consumer Price Index for all-urban consumers), and direct the Secretary to transfer to the Foundation funds donated for Indian health and held by HHS.

Section 3103. GAO Study and Report on Payments for Contract Health Services

This section would require GAO, in consultation with IHS, ITs, and TOs, to study use of health care services provided under the CHS program. The section would require the study to include analyses of amounts reimbursed to providers, suppliers, and entities under CHS, with comparison to reimbursements through other public programs and the private sector; barriers to access to health care under CHS; adequacy of federal funding of CHS; and other items GAO determines appropriate. The section would require GAO to report to Congress on the study within 18 months after enactment, with recommendations on appropriate federal funding for CHS and ways to use such funding efficiently.

Title II of Division D: Improvement of Indian Health Care Provided under the SSA

Separate from the reauthorization of the IHCIA in Section 3101(a), Division D would amend several sections of the SSA specifically those related to titles XVIII (Medicare), XIX (Medicaid), XXI (CHIP), and XI (general provisions).

H.R. 3962 would amend the SSA to define a number of Indian terms as they are defined in IHCIA Section 4. These terms include IHS, IT, TOs, and UIOs, IHPs and THPs. These definitions would apply for all of the SSA including Medicare, Medicaid and CHIP. Section 3201 also includes these definitions as related to amending SSA Sections 1101, 1911, 1880, and 2107.

Section 3201. Expansion of Payments under SSA Health Benefit Programs

(a) Medicaid

This subsection would amend SSA Section 1911(a) to provide that IHPs are eligible for Medicaid payments for all items and services provided under a state plan or under a waiver, if the provision

of those services meets all the conditions and requirements generally applicable to the delivery of such care. The subsection would repeal SSA Section 1911(b) regarding IHS-funded facilities that do not yet meet all conditions and requirements. The subsection would amend SSA Section 1911(c)[53] to permit the Secretary to enter into an agreement with a state for the purpose of reimbursing that state for Medicaid services provided by the IHS, an IT, TO, or UIO, either directly, through referral, under contracts or other arrangements between these entities and another health care provider, to Indians eligible for Medicaid under the state Medicaid plan or a waiver. The subsection strikes SSA Section 1911(d). It would add a new SSA Section 1911(c)[54] that cross-references the special fund for improvement of IHS facilities in IHCIA Section 401(c)(1) (as amended). It also would add a new Section 1911(d) that cross-references direct-billing provisions in IHCIA Section 401(d) (as amended).

(b) Medicare

This subsection would amend and renumber sections of SSA Section 1880. It would amend SSA 1880(a), regarding Medicare payments to IHS hospitals, to specify that, subject to SSA Section 1880(e) (regarding Medicare physician payments to IHS, IT, and TO facilities) that IHPs are eligible for Medicare payments for items and services furnished by IHPs, provided that the services provided meet all the conditions and requirements generally applicable to delivery of such care under the Medicare program. The subsection would repeal SSA Sections 1880(b) regarding IHS-funded facilities that do not yet meet all conditions and requirements, 1880(c) regarding the special fund for improvement of IHS facilities, and 1880(d) regarding a compliance status report. It would add new Sections 1880(b) and 1880(c) to cross-reference the special fund established under IHCIA Section 401(c) (as amended) and cross-reference the direct billing authority in IHCIA Section 401(d) (as amended). The subsection would also make a conforming change to existing SSA Section 1880(e)(3) (as amended), regarding Medicare Part B payments, to specify that IHCIA Section 401(c)(1) (as amended) and new SSA Section 1880(b), both regarding the special fund, would not apply to payments made under SSA Section 1880(e).

(c) Application to CHIP

This subsection would amend SSA Section 2107 (regarding Medicaid provisions applicable to CHIP) to apply all but one of the Medicaid provisions in SSA Section 201(a) as amended, above, to the CHIP program, including the provisions regarding eligibility of Indian entities to receive Medicaid reimbursement, compliance with conditions and requirements, agreements with states to provide Medicaid reimbursement to Indian, direct billing, and definitions of Indian terms. The provision regarding the special fund for improvement of IHS facilities (as defined in the new SSA Section 1911(c))[55] would not apply to CHIP.

Section 3202. Outreach and Enrollment Indians in CHIP and Medicaid

This section would amend SSA Section 2102, regarding assurances required in state CHIP plans, to strike the definition of "Indian" by reference to IHCIA Section 4(c) from the requirement for a

[53] Reference to Section 1911(c) appears to be a drafting error and may refer to Section 1911(b).

[54] Section 1911(c) would likely need to be renumbered based on the other amendments made to SSA Section 1911 in this section.

[55] See above discussion of renumbering.

description in the plan of procedures to ensure the provision of child health assistance to targeted low-income Indian children in the state, and add to the requirement a description of how the state will ensure that payments are made to Indian health programs and urban Indian organizations providing CHIP benefits in the state. The section also would amend SSA Section 2105 regarding the prohibition of CHIP payments where other federal payments can be made, to exempt health care programs operated or financed by IHS, tribes, and TOs and UIOs from such prohibitions (currently only IHS programs are exempted).

Section 3203. SSA Safe Harbor Proposals for IHPs and UIOs

SSA Sections 1128 and 1128B and related provisions exclude certain activities for individuals and entities under federal health programs, but allow waivers and "safe harbors" under certain circumstances. Among the excluded activities are knowingly and willfully soliciting or receiving remuneration in return for referrals for services for which a federal health program payment may be made, or in return for purchasing, leasing, or ordering (or arranging for same) any good, facility, service, or item for which a federal health program payment may be made. This section would direct the Secretary, through the HHS Inspector General, to publish a notice soliciting a proposal, on the development of safe harbors as described for health care items and services provided by IHPs or UIOs. The section would suggest potential areas that these safe harbor may relate to.

Section 3204. SSA Health Benefit Programs Annual Report on Indians Served

This section would amend SSA Section 1139, as amended, to add a new subsection 1139(e), which would require the Secretary, acting through CMS and IHS, to submit an annual report to Congress covering the enrollment and health status of Indians receiving items or services under the health benefit programs funded under the SSA during the preceding year. The section would specify the information to be included in the report, including the number of Indians enrolled in or receiving items or services under each such SSA program and under programs funded by IHS; the health status of these Indians, disaggregated by diseases or conditions consistent with individual privacy; the status of IHS, ITs, TOs, or UIOs facilities' compliance with the applicable terms and conditions under Medicare, Medicaid, and CHIP, and the progress being made by such facilities toward achievement and maintenance of compliance; and such other information as the Secretary determines appropriate.

Section 3205. Interstate Coordination Study

This section would require the Secretary to conduct a study to identify barriers to interstate coordination of enrollment and coverage of Medicaid- and CHIP-enrolled children who frequently change their state of residence or may be temporarily outside their state of residence for a variety of reasons (e.g., educational needs, family migration, or emergency evacuations). The section would require that the study include an examination of enrollment and coverage coordination issues faced by Medicaid- and CHIP-enrolled Indian children temporarily residing in an out-of-state BIA boarding school or peripheral dormitory. [56] The section would also require the Secretary, in consultation with state Medicaid and CHIP directors, to submit a report to Congress, not later than 18 months after enactment, containing recommendations for legislative

[56] The BIA's educational programs were transferred to a new agency, the Bureau of Indian Education (BIE), in 2006.

and administrative actions to address the enrollment and coverage coordination barriers identified in the study.

Appendix. Acronyms used in the Report

ARRA	American Recovery and Reinvestment Act
BIA	Bureau of Indian Affairs
BIE	Bureau of Indian Education
CDC	Centers for Disease Control and Prevention
CHAP	Community Health Aide Program
CHEF	Catastrophic Health Emergency Fund
CHIP	Children's Health Insurance Program
CHR	Community Health Representative
CHS	Contract Health Services
CMS	Centers for Medicare and Medicaid Services
DOD	Department of Defense
FAD	fetal alcohol disorder
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HUD	Department of Housing and Urban Development
IHCIA	Indian Health Care Improvement Act
IHCIF	Indian Health Care Improvement Fund
IHP	Indian Health Program
IHS	Indian Health Service
INMED	Indians into Medicine Program
IRC	Internal Revenue Code
ISDEAA	Indian Self-Determination and Education Assistance Act
IT	Indian tribe
NHSC	National Health Service Corp
PHS	Public Health Service
PHSA	Public Health Service Act
SCHIP	State Children's Health Insurance Program
SSA	Social Security Act
SAMSHA	Substance Abuse and Mental Health Services Administration
THP	Tribal Health Program
TO	tribal organization
UIHP	urban Indian health project
UIO	urban Indian organization
USPSTF	United States Preventive Services Task Force
VA	Department of Veterans Affairs

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