

115TH CONGRESS
1ST SESSION

H. R. 1369

To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 6, 2017

Mr. COLE introduced the following bill; which was referred to the Committee on Natural Resources, and in addition to the Committees on Energy and Commerce, Ways and Means, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Indian Healthcare Improvement Act of 2017”.

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

Sec. 1. Short title; table of contents.

TITLE I—INDIAN HEALTH CARE IMPROVEMENT ACT
REAUTHORIZATION AND AMENDMENTS

- Sec. 101. Reauthorization.
- Sec. 102. Findings.
- Sec. 103. Declaration of national Indian health policy.
- Sec. 104. Definitions.

Subtitle A—Indian Health Manpower

- Sec. 111. Community Health Aide Program.
- Sec. 112. Health professional chronic shortage demonstration programs.
- Sec. 113. Exemption from payment of certain fees.

Subtitle B—Health Services

- Sec. 121. Indian Health Care Improvement Fund.
- Sec. 122. Catastrophic Health Emergency Fund.
- Sec. 123. Diabetes prevention, treatment, and control.
- Sec. 124. Other authority for provision of services; shared services for long-term care.
- Sec. 125. Reimbursement from certain third parties of costs of health services.
- Sec. 126. Crediting of reimbursements.
- Sec. 127. Behavioral health training and community education programs.
- Sec. 128. Cancer screenings.
- Sec. 129. Patient travel costs.
- Sec. 130. Epidemiology centers.
- Sec. 131. Indian youth grant program.
- Sec. 132. American Indians Into Psychology Program.
- Sec. 133. Prevention, control, and elimination of communicable and infectious diseases.
- Sec. 134. Methods to increase clinician recruitment and retention issues.
- Sec. 135. Liability for payment.
- Sec. 136. Offices of Indian Men's Health and Indian Women's Health.
- Sec. 137. Contract health service administration and disbursement formula.

Subtitle C—Health Facilities

- Sec. 141. Health care facility priority system.
- Sec. 142. Priority of certain projects protected.
- Sec. 143. Indian health care delivery demonstration projects.
- Sec. 144. Tribal management of federally owned quarters.
- Sec. 145. Other funding, equipment, and supplies for facilities.
- Sec. 146. Indian country modular component facilities demonstration program.
- Sec. 147. Mobile health stations demonstration program.

Subtitle D—Access to Health Services

- Sec. 151. Treatment of payments under Social Security Act health benefits programs.
- Sec. 152. Purchasing health care coverage.
- Sec. 153. Grants to and contracts with the Service, Indian tribes, tribal organizations, and urban Indian organizations to facilitate outreach, enrollment, and coverage of Indians under Social Security Act health benefit programs and other health benefits programs.
- Sec. 154. Sharing arrangements with Federal agencies.
- Sec. 155. Eligible Indian veteran services.
- Sec. 156. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services.
- Sec. 157. Access to Federal insurance.

- Sec. 158. General exceptions.
- Sec. 159. Navajo Nation Medicaid Agency feasibility study.

Subtitle E—Health Services for Urban Indians

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

Subtitle F—Organizational Improvements

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

Subtitle G—Behavioral Health Programs

- Sec. 181. Behavioral health programs.

Subtitle H—Miscellaneous

- Sec. 191. Confidentiality of medical quality assurance records; qualified immunity for participants.
- Sec. 192. Limitation on use of funds appropriated to the Indian Health Service.
- Sec. 193. Arizona, North Dakota, and South Dakota as contract health service delivery areas; eligibility of California Indians.
- Sec. 194. Methods to increase access to professionals of certain corps.
- Sec. 195. Health services for ineligible persons.
- Sec. 196. Annual budget submission.
- Sec. 197. Prescription drug monitoring.
- Sec. 198. Tribal health program option for cost sharing.
- Sec. 199. Disease and injury prevention report.
- Sec. 200. Other GAO reports.
- Sec. 201. Traditional health care practices.
- Sec. 202. Director of HIV/AIDS Prevention and Treatment.

TITLE II—AMENDMENTS TO OTHER ACTS AND MISCELLANEOUS PROVISIONS

- Sec. 201. Elimination of sunset for reimbursement for all Medicare part B services furnished by certain indian hospitals and clinics.
- Sec. 202. Including costs incurred by aids drug assistance programs and indian health service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
- Sec. 203. Prohibition of use of Federal funds for abortion.
- Sec. 204. Reauthorization of Native Hawaiian health care programs.

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

5 **SEC. 101. REAUTHORIZATION.**

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

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

10 “There are authorized to be appropriated such sums
11 as are necessary to carry out this Act for fiscal year 2017
12 and each fiscal year thereafter, to remain available until
13 expended.”.

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

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

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

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

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

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

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

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

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

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

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

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

6 (c) CONFORMING AMENDMENTS.—

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

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

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

20 **SEC. 102. FINDINGS.**

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

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

1 tively, and indenting the paragraphs appropriately;
2 and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **SEC. 104. DEFINITIONS.**

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

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

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

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

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

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

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

1 “(2) BEHAVIORAL HEALTH.—

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

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

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

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

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

20 “(B) a junior or community college.

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

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

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

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

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

9 “(7) DISEASE PREVENTION.—

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

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

14 “(I) disease; and

15 “(II) complications of disease;

16 and

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

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

21 “(i) controlling—

22 “(I) the development of diabetes;

23 “(II) high blood pressure;

24 “(III) infectious agents;

25 “(IV) injuries;

1 “(V) occupational hazards and
2 disabilities;

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

5 “(VII) toxic agents; or

6 “(ii) providing—

7 “(I) fluoridation of water; or

8 “(II) immunizations.”;

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

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

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

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

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

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

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

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

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

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

“(D) making available safe water and sanitary facilities;

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

“(F) promoting culturally competent care; and

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

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

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

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

1 “(A) any health program administered di-
2 rectly by the Service;

3 “(B) any tribal health program; and

4 “(C) any Indian tribe or tribal organiza-
5 tion to which the Secretary provides funding
6 pursuant to section 23 of the Act of June 25,
7 1910 (25 U.S.C. 47) (commonly known as the
8 ‘Buy Indian Act’).”;

9 (10) by inserting after paragraph (14) (as re-
10 designated by paragraph (3)) the following:

11 “(15) JUNIOR OR COMMUNITY COLLEGE.—The
12 term ‘junior or community college’ has the meaning
13 given the term in section 312(e) of the Higher Edu-
14 cation Act of 1965 (20 U.S.C. 1058(e)).

15 “(16) RESERVATION.—

16 “(A) IN GENERAL.—The term ‘reservation’
17 means a reservation, Pueblo, or colony of any
18 Indian tribe.

19 “(B) INCLUSIONS.—The term ‘reservation’
20 includes—

21 “(i) former reservations in Oklahoma;

22 “(ii) Indian allotments; and

23 “(iii) Alaska Native Regions estab-
24 lished pursuant to the Alaska Native

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

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

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

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

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

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

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

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

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

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

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

17 **Subtitle A—Indian Health**

18 **Manpower**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 “(7) ensure that—

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

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

22 “(c) PROGRAM REVIEW.—

23 “(1) NEUTRAL PANEL.—

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

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

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

8 “(2) STUDY.—

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

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

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

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

1 address the dental care needs of Alaska
2 Natives;

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

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

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

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

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

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

1 “(d) NATIONALIZATION OF PROGRAM.—

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

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

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

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

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

19 “(A) IN GENERAL.—Subparagraph (B) of
20 paragraph (2) shall not apply in the case of an
21 election made by an Indian tribe or tribal orga-
22 nization located in a State (other than Alaska)
23 in which the use of dental health aide therapist
24 services or midlevel dental health provider serv-

1 ices is authorized under State law to supply
2 such services in accordance with State law.

3 “(B) ACTION BY SECRETARY.—On an elec-
4 tion by an Indian tribe or tribal organization
5 under subparagraph (A), the Secretary, acting
6 through the Service, shall facilitate implementa-
7 tion of the services elected.

8 “(4) VACANCIES.—The Secretary shall not fill
9 any vacancy for a certified dentist in a program op-
10 erated by the Service with a dental health aide ther-
11 apist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 **Subtitle B—Health Services**

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

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

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

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

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

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

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

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

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

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

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

18 “(C) Dental care.

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

25 “(E) Emergency medical services.

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

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

8 “(H) Home health care.

9 “(I) Community health representatives.

10 “(J) Maintenance and improvement.

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

17 “(c) ALLOCATION; USE.—

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

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

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

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

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

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

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

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

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

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

20 “(f) REPORT.—By no later than the date that is 3
21 years after the date of enactment of the Indian Healthcare
22 Improvement Act of 2017, the Secretary shall submit to
23 Congress the current health status and resource deficiency
24 report of the Service for each Service unit, including newly

1 recognized or acknowledged Indian tribes. Such report
2 shall set out—

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

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

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

14 “(4) an estimate of—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 “(A) Service Units; or

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(c) DIABETES PROJECTS.—The Secretary shall con-
2 tinue to maintain each model diabetes project in existence
3 on the date of enactment of the Indian Healthcare Im-
4 provement Act of 2017, any such other diabetes programs
5 operated by the Service or tribal health programs, and any
6 additional diabetes projects, such as the Medical Vanguard
7 program provided for in title IV of Public Law 108–87,
8 as implemented to serve Indian tribes. tribal health pro-
9 grams shall receive recurring funding for the diabetes
10 projects that they operate pursuant to this section, both
11 at the date of enactment of the Indian Healthcare Im-
12 provement Act of 2017 and for projects which are added
13 and funded thereafter.

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

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

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

22 “(A) in each area office, consult with In-
23 dian tribes and tribal organizations regarding
24 programs for the prevention, treatment, and
25 control of diabetes;

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

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

10 “(2) DIABETES CONTROL OFFICERS.—

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

20 “(B) CERTAIN ACTIVITIES.—Any activity
21 carried out by a diabetes control officer under
22 subparagraph (A) that is the subject of a con-
23 tract or compact under the Indian Self-Deter-
24 mination and Education Assistance Act (25
25 U.S.C. 450 et seq.), and any funds made avail-

1 able to carry out such an activity, shall not be
2 divisible for purposes of that Act.”.

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

6 (a) OTHER AUTHORITY FOR PROVISION OF SERV-
7 ICES.—

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

11 **“SEC. 205. OTHER AUTHORITY FOR PROVISION OF SERV-**
12 **ICES.**

13 “(a) DEFINITIONS.—In this section:

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

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

22 “(B) shall meet all applicable standards
23 for licensure.

24 “(2) HOME- AND COMMUNITY-BASED SERV-
25 ICE.—The term ‘home- and community-based serv-

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

9 “(3) HOSPICE CARE.—The term ‘hospice care’
 10 means—

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

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

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

23 “(b) FUNDING AUTHORIZED.—The Secretary, acting
 24 through the Service, Indian tribes, and tribal organiza-
 25 tions, may provide funding under this Act to meet the ob-

1 jectives set forth in section 3 through health care-related
2 services and programs not otherwise described in this Act
3 for the following services:

4 “(1) Hospice care.

5 “(2) Assisted living services.

6 “(3) Long-term care services.

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

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

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

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

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

20 “(d) AUTHORIZATION OF CONVENIENT CARE SERV-
21 ICES.—The Secretary, acting through the Service, Indian
22 tribes, and tribal organizations, may also provide funding
23 under this Act to meet the objectives set forth in section
24 3 for convenient care services programs pursuant to sec-
25 tion 307(c)(2)(A).”.

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

4 (b) SHARED SERVICES FOR LONG-TERM CARE.—
5 Section 822 of the Indian Health Care Improvement Act
6 (25 U.S.C. 1680l) is amended to read as follows:

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

8 **“(a) LONG-TERM CARE.—**

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

18 **“(2) INCLUSIONS.—**Each agreement under
19 paragraph (1) shall provide for the sharing of staff
20 or other services between the Service or a tribal
21 health program and a long-term care or related facil-
22 ity owned and operated (directly or through a con-
23 tract or compact under the Indian Self-Determina-
24 tion and Education Assistance Act (25 U.S.C. 450
25 et seq.)) by the Indian tribe or tribal organization.

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

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

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

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

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

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

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

5 **SEC. 125. REIMBURSEMENT FROM CERTAIN THIRD PAR-**
6 **TIES OF COSTS OF HEALTH SERVICES.**

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

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

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

1 ices, would be eligible to receive damages, reimbursement,
2 or indemnification for such charges or expenses if—

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

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

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

12 “(1) workers’ compensation laws; or

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

15 “(c) NONAPPLICABILITY OF OTHER LAWS.—No law
16 of any State, or of any political subdivision of a State and
17 no provision of any contract, insurance or health mainte-
18 nance organization policy, employee benefit plan, self-in-
19 surance plan, managed care plan, or other health care plan
20 or program entered into or renewed after the date of en-
21 actment of the Indian Health Care Amendments of 1988,
22 shall prevent or hinder the right of recovery of the United
23 States, an Indian tribe, or tribal organization under sub-
24 section (a).

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

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

7 “(e) ENFORCEMENT.—

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

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

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

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

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

24 “(2) NOTICE.—All reasonable efforts shall be
25 made to provide notice of action instituted under

1 paragraph (1)(B) to the individual to whom health
2 services were provided, either before or during the
3 pendency of such action.

4 “(3) RECOVERY FROM TORTFEASORS.—

5 “(A) IN GENERAL.—In any case in which
6 an Indian tribe or tribal organization that is
7 authorized or required under a compact or con-
8 tract issued pursuant to the Indian Self-Deter-
9 mination and Education Assistance Act (25
10 U.S.C. 450 et seq.) to furnish or pay for health
11 services to a person who is injured or suffers a
12 disease on or after the date of enactment of the
13 Indian Healthcare Improvement Act of 2017
14 under circumstances that establish grounds for
15 a claim of liability against the tortfeasor with
16 respect to the injury or disease, the Indian tribe
17 or tribal organization shall have a right to re-
18 cover from the tortfeasor (or an insurer of the
19 tortfeasor) the reasonable value of the health
20 services so furnished, paid for, or to be paid
21 for, in accordance with the Federal Medical
22 Care Recovery Act (42 U.S.C. 2651 et seq.), to
23 the same extent and under the same cir-
24 cumstances as the United States may recover
25 under that Act.

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

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

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

24 “(h) NONAPPLICABILITY OF CLAIMS FILING RE-
25 QUIREMENTS.—An insurance company, health mainte-

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

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

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

23 “(k) SAVINGS.—Nothing in this section shall be con-
24 strued to limit any right of recovery available to the
25 United States, an Indian tribe, or tribal organization

1 under the provisions of any applicable, Federal, State, or
2 tribal law, including medical lien laws.”.

3 **SEC. 126. CREDITING OF REIMBURSEMENTS.**

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

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

7 “(a) USE OF AMOUNTS.—

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

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

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

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

1 “(C) Public Law 87–693.

2 “(D) Any other provision of law.

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

7 **SEC. 127. BEHAVIORAL HEALTH TRAINING AND COMMU-**
8 **NITY EDUCATION PROGRAMS.**

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

12 “(d) BEHAVIORAL HEALTH TRAINING AND COMMU-
13 NITY EDUCATION PROGRAMS.—

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

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

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

4 “(i) elementary and secondary edu-
5 cation;

6 “(ii) social services and family and
7 child welfare;

8 “(iii) law enforcement and judicial
9 services; and

10 “(iv) alcohol and substance abuse;

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

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

17 “(3) TRAINING CRITERIA.—

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

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

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

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

1 nization, provide technical assistance to the Indian
2 tribe, tribal organization, or urban Indian organiza-
3 tion to obtain and develop community educational
4 materials on the identification, prevention, referral,
5 and treatment of mental illness and dysfunctional
6 and self-destructive behavior.

7 “(5) PLAN.—Not later than 90 days after the
8 date of enactment of the Indian Healthcare Im-
9 provement Act of 2017, the Secretary shall develop
10 a plan under which the Service will increase the
11 health care staff providing behavioral health services
12 by at least 500 positions within 5 years after the
13 date of enactment of that Act, with at least 200 of
14 such positions devoted to child, adolescent, and fam-
15 ily services. The plan developed under this para-
16 graph shall be implemented under the Act of No-
17 vember 2, 1921 (25 U.S.C. 13) (commonly known as
18 the ‘Snyder Act’).”.

19 **SEC. 128. CANCER SCREENINGS.**

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

23 **SEC. 129. PATIENT TRAVEL COSTS.**

24 Section 213 of the Indian Health Care Improvement
25 Act (25 U.S.C. 1621l) is amended to read as follows:

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

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

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

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

11 “(3) other escorts, as the Secretary or applica-
12 ble Indian Health Program determines to be appro-
13 priate.

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

22 “(1) emergency air transportation and non-
23 emergency air transportation where ground trans-
24 portation is infeasible;

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

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

7 **SEC. 130. EPIDEMIOLOGY CENTERS.**

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

10 **“SEC. 214. EPIDEMIOLOGY CENTERS.**

11 **“(a) ESTABLISHMENT OF CENTERS.—**

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

15 **“(2) NEW CENTERS.—**

16 **“(A) IN GENERAL.—**Subject to subpara-
 17 graph (B), any new center established after the
 18 date of enactment of the Indian Healthcare Im-
 19 provement Act of 2017 may be operated under
 20 a grant authorized by subsection (d).

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

24 **“(3) FUNDS NOT DIVISIBLE.—**An epidemiology
 25 center established under this subsection shall be sub-

1 ject to the Indian Self-Determination and Education
2 Assistance Act (25 U.S.C. 450 et seq.), but the
3 funds for the center shall not be divisible.

4 “(b) FUNCTIONS OF CENTERS.—In consultation with
5 and on the request of Indian tribes, tribal organizations,
6 and urban Indian organizations, each Service area epide-
7 miology center established under this section shall, with
8 respect to the applicable Service area—

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

14 “(2) evaluate existing delivery systems, data
15 systems, and other systems that impact the improve-
16 ment of Indian health;

17 “(3) assist Indian tribes, tribal organizations,
18 and urban Indian organizations in identifying high-
19 est-priority health status objectives and the services
20 needed to achieve those objectives, based on epide-
21 miological data;

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

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

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

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

9 “(c) TECHNICAL ASSISTANCE.—The Director of the
10 Centers for Disease Control and Prevention shall provide
11 technical assistance to the centers in carrying out this sec-
12 tion.

13 “(d) GRANTS FOR STUDIES.—

14 “(1) IN GENERAL.—The Secretary may make
15 grants to Indian tribes, tribal organizations, Indian
16 organizations, and eligible intertribal consortia to
17 conduct epidemiological studies of Indian commu-
18 nities.

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

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

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

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

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

10 “(A) demonstrate the technical, adminis-
11 trative, and financial expertise necessary to
12 carry out the functions described in paragraph
13 (5);

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

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

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

22 “(A) to carry out the functions described
23 in subsection (b);

24 “(B) to provide information to, and consult
25 with, tribal leaders, urban Indian community

1 leaders, and related health staff regarding
2 health care and health service management
3 issues; and

4 “(C) in collaboration with Indian tribes,
5 tribal organizations, and urban Indian organi-
6 zations, to provide to the Service information
7 regarding ways to improve the health status of
8 Indians.

9 “(e) ACCESS TO INFORMATION.—

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

18 “(2) ACCESS TO INFORMATION.—The Secretary
19 shall grant to each epidemiology center described in
20 paragraph (1) access to use of the data, data sets,
21 monitoring systems, delivery systems, and other pro-
22 tected health information in the possession of the
23 Secretary.

24 “(3) REQUIREMENT.—The activities of an epi-
25 demiology center described in paragraph (1) shall be

1 for the purposes of research and for preventing and
 2 controlling disease, injury, or disability (as those ac-
 3 tivities are described in section 164.512 of title 45,
 4 Code of Federal Regulations (or a successor regula-
 5 tion)), for purposes of the Health Insurance Port-
 6 ability and Accountability Act of 1996 (Public
 7 Law 104–191; 110 Stat. 1936).”.

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

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

12 **SEC. 132. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
 13 **GRAM.**

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

16 **“SEC. 217. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
 17 **GRAM.**

18 “(a) GRANTS AUTHORIZED.—The Secretary, acting
 19 through the Service, shall make grants of not more than
 20 \$300,000 to each of 9 colleges and universities for the pur-
 21 pose of developing and maintaining Indian psychology ca-
 22 reer recruitment programs as a means of encouraging In-
 23 dians to enter the behavioral health field. These programs
 24 shall be located at various locations throughout the coun-
 25 try to maximize their availability to Indian students and

1 new programs shall be established in different locations
2 from time to time.

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

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

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

20 “(1) provides outreach and recruitment for
21 health professions to Indian communities including
22 elementary, secondary, and accredited and accessible
23 community colleges that will be served by the pro-
24 gram;

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

4 “(3) provides summer enrichment programs to
5 expose Indian students to the various fields of psy-
6 chology through research, clinical, and experimental
7 activities;

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

10 “(5) develops affiliation agreements with tribal
11 colleges and universities, the Service, university af-
12 filiated programs, and other appropriate accredited
13 and accessible entities to enhance the education of
14 Indian students;

15 “(6) to the maximum extent feasible, uses exist-
16 ing university tutoring, counseling, and student sup-
17 port services; and

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

20 “(e) ACTIVE DUTY SERVICE REQUIREMENT.—The
21 active duty service obligation prescribed under section
22 338C of the Public Health Service Act (42 U.S.C. 254m)
23 shall be met by each graduate who receives a stipend de-
24 scribed in subsection (d)(4) that is funded under this sec-
25 tion. Such obligation shall be met by service—

1 “(1) in an Indian health program;

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

3 “(3) in the private practice of psychology if, as
4 determined by the Secretary, in accordance with
5 guidelines promulgated by the Secretary, such prac-
6 tice is situated in a physician or other health profes-
7 sional shortage area and addresses the health care
8 needs of a substantial number of Indians.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
10 is authorized to be appropriated to carry out this section
11 \$2,700,000 for fiscal year 2017 and each fiscal year there-
12 after.”.

13 **SEC. 133. PREVENTION, CONTROL, AND ELIMINATION OF**
14 **COMMUNICABLE AND INFECTIOUS DISEASES.**

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

17 **“SEC. 218. PREVENTION, CONTROL, AND ELIMINATION OF**
18 **COMMUNICABLE AND INFECTIOUS DISEASES.**

19 “(a) GRANTS AUTHORIZED.—The Secretary, acting
20 through the Service, and after consultation with the Cen-
21 ters for Disease Control and Prevention, may make grants
22 available to Indian tribes and tribal organizations for the
23 following:

24 “(1) Projects for the prevention, control, and
25 elimination of communicable and infectious diseases,

1 including tuberculosis, hepatitis, HIV, respiratory
2 syncytial virus, hanta virus, sexually transmitted dis-
3 eases, and H. pylori.

4 “(2) Public information and education pro-
5 grams for the prevention, control, and elimination of
6 communicable and infectious diseases.

7 “(3) Education, training, and clinical skills im-
8 provement activities in the prevention, control, and
9 elimination of communicable and infectious diseases
10 for health professionals, including allied health pro-
11 fessionals.

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

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

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

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

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

3 “(2) shall prepare and submit a report to Con-
4 gress biennially on the use of funds under this sec-
5 tion and on the progress made toward the preven-
6 tion, control, and elimination of communicable and
7 infectious diseases among Indians and urban Indi-
8 ans.”.

9 **SEC. 134. METHODS TO INCREASE CLINICIAN RECRUIT-**
10 **MENT AND RETENTION ISSUES.**

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

14 **“SEC. 221. LICENSING.**

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

22 (b) **CONTINUING EDUCATION ALLOWANCES.**—Sec-
23 tion 106 of the Indian Health Care Improvement Act (25
24 U.S.C. 1615) is amended to read as follows:

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

2 “In order to encourage scholarship and stipend re-
3 cipients under sections 104, 105, and 115 and health pro-
4 fessionals, including community health representatives
5 and emergency medical technicians, to join or continue in
6 an Indian health program and to provide services in the
7 rural and remote areas in which a significant portion of
8 Indians reside, the Secretary, acting through the Service,
9 may—

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

15 “(2) provide programs or allowances to health
16 professionals employed in an Indian health program
17 to enable those professionals, for a period of time
18 each year prescribed by regulation of the Secretary,
19 to take leave of the duty stations of the professionals
20 for professional consultation, management, leader-
21 ship, and refresher training courses.”.

22 **SEC. 135. LIABILITY FOR PAYMENT.**

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

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

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

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

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

19 **SEC. 136. OFFICES OF INDIAN MEN’S HEALTH AND INDIAN**
20 **WOMEN’S HEALTH.**

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

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

1 **“SEC. 223. OFFICES OF INDIAN MEN’S HEALTH AND INDIAN**
2 **WOMEN’S HEALTH.**

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

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

7 “(2) DIRECTOR.—

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

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

14 “(3) REPORT.—Not later than 2 years after the
15 date of enactment of the Indian Healthcare Improve-
16 ment Act of 2017, the Secretary, acting through the
17 Service, shall submit to Congress a report describ-
18 ing—

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

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

24 “(b) OFFICE OF INDIAN WOMEN’S HEALTH.—The
25 Secretary, acting through the Service, shall establish an

1 office, to be known as the ‘Office of Indian Women’s
2 Health’, to’’; and

3 (2) in subsection (b) (as so redesignated) by in-
4 serting “(including urban Indian women)” before
5 “of all ages”.

6 **SEC. 137. CONTRACT HEALTH SERVICE ADMINISTRATION**
7 **AND DISBURSEMENT FORMULA.**

8 Title II of the Indian Health Care Improvement Act
9 (25 U.S.C. 1621 et seq.) is amended by adding at the end
10 the following:

11 **“SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION**
12 **AND DISBURSEMENT FORMULA.**

13 “(a) SUBMISSION OF REPORT.—As soon as prac-
14 ticable after the date of enactment of the Indian
15 Healthcare Improvement Act of 2017, the Comptroller
16 General of the United States shall submit to the Sec-
17 retary, the Committee on Indian Affairs of the Senate,
18 and the Committee on Natural Resources of the House
19 of Representatives, and make available to each Indian
20 tribe, a report describing the results of the study of the
21 Comptroller General regarding the funding of the contract
22 health service program (including historic funding levels
23 and a recommendation of the funding level needed for the
24 program) and the administration of the contract health
25 service program (including the distribution of funds pur-

1 suant to the program), as requested by Congress in March
2 2009, or pursuant to section 830.

3 “(b) CONSULTATION WITH TRIBES.—On receipt of
4 the report under subsection (a), the Secretary shall con-
5 sult with Indian tribes regarding the contract health serv-
6 ice program, including the distribution of funds pursuant
7 to the program—

8 “(1) to determine whether the current distribu-
9 tion formula would require modification if the con-
10 tract health service program were funded at the level
11 recommended by the Comptroller General;

12 “(2) to identify any inequities in the current
13 distribution formula under the current funding level
14 or inequitable results for any Indian tribe under the
15 funding level recommended by the Comptroller Gen-
16 eral;

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

20 “(4) to identify any other issues and rec-
21 ommendations to improve the administration of the
22 contract health services program and correct any un-
23 fair results or funding disparities identified under
24 paragraph (2).

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

9 **Subtitle C—Health Facilities**

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

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

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

15 (2) by striking subsection (c) and inserting the
 16 following:

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

18 “(1) IN GENERAL.—

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

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

24 “(ii) shall give Indian tribes’ needs
 25 the highest priority;

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

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

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

9 “(iv) shall provide an opportunity for
10 the nomination of planning, design, and
11 construction projects by the Service, In-
12 dian tribes, and tribal organizations for
13 consideration under the priority system at
14 least once every 3 years, or more fre-
15 quently as the Secretary determines to be
16 appropriate.

17 “(B) NEEDS OF FACILITIES UNDER
18 ISDEAA AGREEMENTS.—The Secretary shall en-
19 sure that the planning, design, construction,
20 renovation, and expansion needs of Service and
21 non-Service facilities operated under contracts
22 or compacts in accordance with the Indian Self-
23 Determination and Education Assistance Act
24 (25 U.S.C. 450 et seq.) are fully and equitably

1 integrated into the health care facility priority
2 system.

3 “(C) CRITERIA FOR EVALUATING
4 NEEDS.—For purposes of this subsection, the
5 Secretary, in evaluating the needs of facilities
6 operated under a contract or compact under the
7 Indian Self-Determination and Education As-
8 sistance Act (25 U.S.C. 450 et seq.), shall use
9 the criteria used by the Secretary in evaluating
10 the needs of facilities operated directly by the
11 Service.

12 “(D) PRIORITY OF CERTAIN PROJECTS
13 PROTECTED.—The priority of any project estab-
14 lished under the construction priority system in
15 effect on the date of enactment of the Indian
16 Healthcare Improvement Act of 2017 shall not
17 be affected by any change in the construction
18 priority system taking place after that date if
19 the project—

20 “(i) was identified in the fiscal year
21 2008 Service budget justification as—

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

24 “(II) 1 of the 10 top-priority out-
25 patient projects;

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

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

5 “(ii) had completed both Phase I and
6 Phase II of the construction priority sys-
7 tem in effect on the date of enactment of
8 such Act; or

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

12 “(I) on the initiative of the Sec-
13 retary; or

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

16 “(2) REPORT; CONTENTS.—

17 “(A) INITIAL COMPREHENSIVE REPORT.—

18 “(i) DEFINITIONS.—In this subpara-
19 graph:

20 “(I) FACILITIES APPROPRIATION
21 ADVISORY BOARD.—The term ‘Facili-
22 ties Appropriation Advisory Board’
23 means the advisory board, comprised
24 of 12 members representing Indian
25 tribes and 2 members representing

1 the Service, established at the discre-
2 tion of the Director—

3 “(aa) to provide advice and
4 recommendations for policies and
5 procedures of the programs fund-
6 ed pursuant to facilities appro-
7 priations; and

8 “(bb) to address other facili-
9 ties issues.

10 “(II) FACILITIES NEEDS ASSESS-
11 MENT WORKGROUP.—The term ‘Fa-
12 cilities Needs Assessment Workgroup’
13 means the workgroup established at
14 the discretion of the Director—

15 “(aa) to review the health
16 care facilities construction pri-
17 ority system; and

18 “(bb) to make recommenda-
19 tions to the Facilities Appropria-
20 tion Advisory Board for revising
21 the priority system.

22 “(ii) INITIAL REPORT.—

23 “(I) IN GENERAL.—Not later
24 than 1 year after the date of enact-
25 ment of the Indian Healthcare Im-

1 provement Act of 2017, the Secretary
2 shall submit to the Committee on In-
3 dian Affairs of the Senate and the
4 Committee on Natural Resources of
5 the House of Representatives a report
6 that describes the comprehensive, na-
7 tional, ranked list of all health care
8 facilities needs for the Service, Indian
9 tribes, and tribal organizations (in-
10 cluding inpatient health care facilities,
11 outpatient health care facilities, spe-
12 cialized health care facilities (such as
13 for long-term care and alcohol and
14 drug abuse treatment), wellness cen-
15 ters, and staff quarters, and the ren-
16 ovation and expansion needs, if any,
17 of such facilities) developed by the
18 Service, Indian tribes, and tribal orga-
19 nizations for the Facilities Needs As-
20 sessment Workgroup and the Facili-
21 ties Appropriation Advisory Board.

22 “(II) INCLUSIONS.—The initial
23 report shall include—

24 “(aa) the methodology and
25 criteria used by the Service in de-

1 termining the needs and estab-
2 lishing the ranking of the facili-
3 ties needs; and

4 “(bb) such other information
5 as the Secretary determines to be
6 appropriate.

7 “(iii) UPDATES OF REPORT.—Begin-
8 ning in calendar year 2017, the Secretary
9 shall—

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

13 “(II) include the updated report
14 in the appropriate annual report
15 under subparagraph (B) for submis-
16 sion to Congress under section 801.

17 “(B) ANNUAL REPORTS.—The Secretary
18 shall submit to the President, for inclusion in
19 the report required to be transmitted to Con-
20 gress under section 801, a report which sets
21 forth the following:

22 “(i) A description of the health care
23 facility priority system of the Service es-
24 tablished under paragraph (1).

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

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

5 “(II) the 10 top-priority out-
6 patient health care facilities;

7 “(III) the 10 top-priority special-
8 ized health care facilities (such as
9 long-term care and alcohol and drug
10 abuse treatment); and

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

14 “(iii) The justification for such order
15 of priority.

16 “(iv) The projected cost of such
17 projects.

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

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

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

4 “(B) review the total unmet needs of all
5 Indian tribes and tribal organizations for health
6 care facilities (including staff quarters), includ-
7 ing needs for renovation and expansion of exist-
8 ing facilities.

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

11 “(1) IN GENERAL.—Not later than 1 year after
12 the establishment of the priority system under sub-
13 section (c)(1)(A), the Comptroller General of the
14 United States shall prepare and finalize a report re-
15 viewing the methodologies applied, and the processes
16 followed, by the Service in making each assessment
17 of needs for the list under subsection (c)(2)(A)(ii)
18 and developing the priority system under subsection
19 (c)(1), including a review of—

20 “(A) the recommendations of the Facilities
21 Appropriation Advisory Board and the Facili-
22 ties Needs Assessment Workgroup (as those
23 terms are defined in subsection (c)(2)(A)(i));
24 and

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

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

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

9 “(B) the Committees on Natural Re-
10 sources and Appropriations of the House of
11 Representatives; and

12 “(C) the Secretary.

13 “(e) FUNDING CONDITION.—All funds appropriated
14 under the Act of November 2, 1921 (25 U.S.C. 13) (com-
15 monly known as the ‘Snyder Act’), for the planning, de-
16 sign, construction, or renovation of health facilities for the
17 benefit of 1 or more Indian Tribes shall be subject to the
18 provisions of section 102 of the Indian Self-Determination
19 and Education Assistance Act (25 U.S.C. 450f) or sec-
20 tions 504 and 505 of that Act (25 U.S.C. 458aaa–3,
21 458aaa–4).

22 “(f) DEVELOPMENT OF INNOVATIVE APPROACHES.—
23 The Secretary shall consult and cooperate with Indian
24 tribes and tribal organizations, and confer with urban In-
25 dian organizations, in developing innovative approaches to

1 address all or part of the total unmet need for construc-
 2 tion of health facilities, that may include—

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

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

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

10 **SEC. 142. PRIORITY OF CERTAIN PROJECTS PROTECTED.**

11 Section 301 of the Indian Health Care Improvement
 12 Act (25 U.S.C. 1631) (as amended by section 141) is
 13 amended by adding at the end the following:

14 “(g) PRIORITY OF CERTAIN PROJECTS PRO-
 15 TECTED.—The priority of any project established under
 16 the construction priority system in effect on the date of
 17 enactment of this Indian Healthcare Improvement Act of
 18 2017 shall not be affected by any change in the construc-
 19 tion priority system taking place after that date if the
 20 project—

21 “(1) was identified in the fiscal year 2008 Serv-
 22 ice budget justification as—

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

1 “(B) 1 of the 10 top-priority outpatient
2 projects;

3 “(C) 1 of the 10 top-priority staff quarters
4 developments; or

5 “(D) 1 of the 10 top-priority Youth Re-
6 gional Treatment Centers;

7 “(2) had completed both Phase I and Phase II
8 of the construction priority system in effect on the
9 date of enactment of such Act; or

10 “(3) is not included in clause (i) or (ii) and is
11 selected, as determined by the Secretary—

12 “(A) on the initiative of the Secretary; or

13 “(B) pursuant to a request of an Indian
14 tribe or tribal organization.”.

15 **SEC. 143. INDIAN HEALTH CARE DELIVERY DEMONSTRA-**
16 **TION PROJECTS.**

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

19 **“SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRA-**
20 **TION PROJECTS.**

21 “(a) PURPOSE AND GENERAL AUTHORITY.—

22 “(1) PURPOSE.—The purpose of this section is
23 to encourage the establishment of demonstration
24 projects that meet the applicable criteria of this sec-
25 tion to be carried out by the Secretary, acting

1 through the Service, or Indian tribes or tribal orga-
2 nizations acting pursuant to contracts or compacts
3 under the Indian Self Determination and Education
4 Assistance Act (25 U.S.C. 450 et seq.)—

5 “(A) to test alternative means of delivering
6 health care and services to Indians through fa-
7 cilities; or

8 “(B) to use alternative or innovative meth-
9 ods or models of delivering health care services
10 to Indians (including primary care services,
11 contract health services, or any other program
12 or service authorized by this Act) through con-
13 venient care services (as defined in subsection
14 (c)), community health centers, or cooperative
15 agreements or arrangements with other health
16 care providers that share or coordinate the use
17 of facilities, funding, or other resources, or oth-
18 erwise coordinate or improve the coordination of
19 activities of the Service, Indian tribes, or tribal
20 organizations, with those of the other health
21 care providers.

22 “(2) AUTHORITY.—The Secretary, acting
23 through the Service, is authorized to carry out, or to
24 enter into contracts or compacts under the Indian
25 Self-Determination and Education Assistance Act

1 (25 U.S.C. 450 et seq.) with Indian tribes or tribal
2 organizations to carry out, health care delivery dem-
3 onstration projects that—

4 “(A) test alternative means of delivering
5 health care and services to Indians through fa-
6 cilities; or

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

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

11 “(1) may authorize such contracts for the con-
12 struction and renovation of hospitals, health centers,
13 health stations, and other facilities to deliver health
14 care services; and

15 “(2) is authorized—

16 “(A) to waive any leasing prohibition;

17 “(B) to permit use and carryover of funds
18 appropriated for the provision of health care
19 services under this Act (including for the pur-
20 chase of health benefits coverage, as authorized
21 by section 402(a));

22 “(C) to permit the use of other available
23 funds, including other Federal funds, funds
24 from third-party collections in accordance with
25 sections 206, 207, and 401, and non-Federal

1 funds contributed by State or local govern-
 2 mental agencies or facilities or private health
 3 care providers pursuant to cooperative or other
 4 agreements with the Service, 1 or more Indian
 5 tribes, or tribal organizations;

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

9 “(E) to provide for the reversion of do-
 10 nated real or personal property to the donor;
 11 and

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

14 “(c) HEALTH CARE DEMONSTRATION PROJECTS.—

15 “(1) DEFINITION OF CONVENIENT CARE SERV-
 16 ICE.—In this subsection, the term ‘convenient care
 17 service’ means any primary health care service, such
 18 as urgent care services, nonemergent care services,
 19 prevention services and screenings, and any service
 20 authorized by section 203 or 205(d), that is of-
 21 fered—

22 “(A) at an alternative setting; or

23 “(B) during hours other than regular
 24 working hours.

25 “(2) GENERAL PROJECTS.—

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

4 “(i) There is a need for a new facility
5 or program, such as a program for conven-
6 ient care services, or an improvement in,
7 increased efficiency at, or reorientation of
8 an existing facility or program.

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

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

15 “(iv) The project is economically via-
16 ble.

17 “(v) For projects carried out by an
18 Indian tribe or tribal organization, the In-
19 dian tribe or tribal organization has the
20 administrative and financial capability to
21 administer the project.

22 “(vi) The project is integrated with
23 providers of related health or social serv-
24 ices (including State and local health care
25 agencies or other health care providers)

1 and is coordinated with, and avoids dupli-
2 cation of, existing services in order to ex-
3 pand the availability of services.

4 “(B) PRIORITY.—In approving demonstra-
5 tion projects under this paragraph, the Sec-
6 retary shall give priority to demonstration
7 projects, to the extent the projects meet the cri-
8 teria described in subparagraph (A), located in
9 any of the following Service units:

10 “(i) Cass Lake, Minnesota.

11 “(ii) Mescalero, New Mexico.

12 “(iii) Owyhee and Elko, Nevada.

13 “(iv) Schurz, Nevada.

14 “(v) Ft. Yuma, California.

15 “(3) INNOVATIVE HEALTH SERVICES DELIVERY
16 DEMONSTRATION PROJECT.—

17 “(A) APPLICATION OR REQUEST.—On re-
18 ceipt of an application or request from an In-
19 dian tribe, a consortium of Indian tribes, or a
20 tribal organization within a Service area, the
21 Secretary shall take into consideration alter-
22 native or innovated methods to deliver health
23 care services within the Service area (or a por-
24 tion of, or facility within, the Service area) as
25 described in the application or request, includ-

1 ing medical, dental, pharmaceutical, nursing,
2 clinical laboratory, contract health services, con-
3 venient care services, community health centers,
4 or any other health care services delivery mod-
5 els designed to improve access to, or efficiency
6 or quality of, the health care, health promotion,
7 or disease prevention services and programs
8 under this Act.

9 “(B) APPROVAL.—In addition to projects
10 described in paragraph (2), in any fiscal year,
11 the Secretary is authorized under this para-
12 graph to approve not more than 10 applications
13 for health care delivery demonstration projects
14 that meet the criteria described in subpara-
15 graph (C).

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

19 “(i) The criteria set forth in para-
20 graph (2)(A).

21 “(ii) There is a lack of access to
22 health care services at existing health care
23 facilities, which may be due to limited
24 hours of operation at those facilities or
25 other factors.

1 “(iii) The project—

2 “(I) expands the availability of
3 services; or

4 “(II) reduces—

5 “(aa) the burden on Con-
6 tract Health Services; or

7 “(bb) the need for emer-
8 gency room visits.

9 “(d) TECHNICAL ASSISTANCE.—On receipt of an ap-
10 plication or request from an Indian tribe, a consortium
11 of Indian tribes, or a tribal organization, the Secretary
12 shall provide such technical and other assistance as may
13 be necessary to enable applicants to comply with this sec-
14 tion, including information regarding the Service unit
15 budget and available funding for carrying out the pro-
16 posed demonstration project.

17 “(e) SERVICE TO INELIGIBLE PERSONS.—Subject to
18 section 813, the authority to provide services to persons
19 otherwise ineligible for the health care benefits of the
20 Service, and the authority to extend hospital privileges in
21 Service facilities to non-Service health practitioners as
22 provided in section 813, may be included, subject to the
23 terms of that section, in any demonstration project ap-
24 proved pursuant to this section.

1 “(f) **EQUITABLE TREATMENT.**—For purposes of sub-
 2 section (c), the Secretary, in evaluating facilities operated
 3 under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450
 4 et seq.), shall use the same criteria that the Secretary uses
 5 in evaluating facilities operated directly by the Service.

7 “(g) **EQUITABLE INTEGRATION OF FACILITIES.**—
 8 The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and
 9 non-Service facilities that are the subject of a contract or
 10 compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health
 11 services are fully and equitably integrated into the implementation of the health care delivery demonstration
 12 projects under this section.”.

16 **SEC. 144. TRIBAL MANAGEMENT OF FEDERALLY OWNED**
 17 **QUARTERS.**

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

21 **“SEC. 309. TRIBAL MANAGEMENT OF FEDERALLY OWNED**
 22 **QUARTERS.**

23 “(a) **RENTAL RATES.**—

24 “(1) **ESTABLISHMENT.**—Notwithstanding any
 25 other provision of law, a tribal health program that

1 operates a hospital or other health facility and the
2 federally owned quarters associated with such a fa-
3 cility pursuant to a contract or compact under the
4 Indian Self-Determination and Education Assistance
5 Act (25 U.S.C. 450 et seq.) may establish the rental
6 rates charged to the occupants of those quarters, on
7 providing notice to the Secretary.

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

11 “(A) to base the rental rates on the rea-
12 sonable value of the quarters to the occupants
13 of the quarters; and

14 “(B) to generate sufficient funds to pru-
15 dently provide for the operation and mainte-
16 nance of the quarters, and at the discretion of
17 the tribal health program, to supply reserve
18 funds for capital repairs and replacement of the
19 quarters.

20 “(3) EQUITABLE FUNDING.—A federally owned
21 quarters the rental rates for which are established
22 by a tribal health program under this subsection
23 shall remain eligible to receive improvement and re-
24 pair funds to the same extent that all federally

1 owned quarters used to house personnel in programs
2 of the Service are eligible to receive those funds.

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

9 “(5) RATES IN ALASKA.—A rental rate estab-
10 lished by a tribal health program under this section
11 for a federally owned quarters in the State of Alaska
12 may be based on the cost of comparable private
13 rental housing in the nearest established community
14 with a year-round population of 1,500 or more indi-
15 viduals.

16 “(b) DIRECT COLLECTION OF RENT.—

17 “(1) IN GENERAL.—Notwithstanding any other
18 provision of law, and subject to paragraph (2), a
19 tribal health program may collect rent directly from
20 Federal employees who occupy federally owned quar-
21 ters if the tribal health program submits to the Sec-
22 retary and the employees a notice of the election of
23 the tribal health program to collect rents directly
24 from the employees.

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

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

7 “(B) the Secretary shall not have the au-
8 thority to collect rent from the employees
9 through payroll deduction or otherwise.

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

12 “(A) shall be retained by the applicable
13 tribal health program in a separate account,
14 which shall be used by the tribal health pro-
15 gram for the maintenance (including capital re-
16 pairs and replacement) and operation of the
17 quarters, as the tribal health program deter-
18 mines to be appropriate; and

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

21 “(4) RETROCESSION OF AUTHORITY.—If a trib-
22 al health program that elected to collect rent directly
23 under paragraph (1) requests retrocession of the au-
24 thority of the tribal health program to collect that

1 rent, the retrocession shall take effect on the earlier
2 of—

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

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

9 **SEC. 145. OTHER FUNDING, EQUIPMENT, AND SUPPLIES**
10 **FOR FACILITIES.**

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

14 **“SEC. 311. OTHER FUNDING, EQUIPMENT, AND SUPPLIES**
15 **FOR FACILITIES.**

16 “(a) AUTHORIZATION.—

17 “(1) AUTHORITY TO TRANSFER FUNDS.—The
18 head of any Federal agency to which funds, equip-
19 ment, or other supplies are made available for the
20 planning, design, construction, or operation of a
21 health care or sanitation facility may transfer the
22 funds, equipment, or supplies to the Secretary for
23 the planning, design, construction, or operation of a
24 health care or sanitation facility to achieve—

25 “(A) the purposes of this Act; and

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

4 “(2) AUTHORITY TO ACCEPT FUNDS.—The Sec-
5 retary may—

6 “(A) accept from any source, including
7 Federal and State agencies, funds, equipment,
8 or supplies that are available for the construc-
9 tion or operation of health care or sanitation fa-
10 cilities; and

11 “(B) use those funds, equipment, and sup-
12 plies to plan, design, construct, and operate
13 health care or sanitation facilities for Indians,
14 including pursuant to a contract or compact
15 under the Indian Self-Determination and Edu-
16 cation Assistance Act (25 U.S.C. 450 et seq.).

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

20 “(b) INTERAGENCY AGREEMENTS.—The Secretary
21 may enter into interagency agreements with Federal or
22 State agencies and other entities, and accept funds, equip-
23 ment, or other supplies from those entities, to provide for
24 the planning, design, construction, and operation of health

1 care or sanitation facilities to be administered by Indian
2 health programs to achieve—

3 “(1) the purposes of this Act; and

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

6 “(c) ESTABLISHMENT OF STANDARDS.—

7 “(1) IN GENERAL.—The Secretary, acting
8 through the Service, shall establish, by regulation,
9 standards for the planning, design, construction, and
10 operation of health care or sanitation facilities serv-
11 ing Indians under this Act.

12 “(2) OTHER REGULATIONS.—Notwithstanding
13 any other provision of law, any other applicable reg-
14 ulations of the Department shall apply in carrying
15 out projects using funds transferred under this sec-
16 tion.

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

1 **SEC. 146. INDIAN COUNTRY MODULAR COMPONENT FACILI-**
2 **TIES DEMONSTRATION PROGRAM.**

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

6 **“SEC. 312. INDIAN COUNTRY MODULAR COMPONENT FA-**
7 **CILITIES DEMONSTRATION PROGRAM.**

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

12 “(1) off-site using prefabricated component
13 units for subsequent transport to the destination lo-
14 cation; and

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

18 “(b) ESTABLISHMENT.—The Secretary, acting
19 through the Service, shall establish a demonstration pro-
20 gram under which the Secretary shall award no less than
21 3 grants for purchase, installation and maintenance of
22 modular component health care facilities in Indian com-
23 munities for provision of health care services.

24 “(c) SELECTION OF LOCATIONS.—

25 “(1) PETITIONS.—

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

6 “(B) PETITION.—To be eligible to receive
7 a grant under this section, an Indian tribe or
8 tribal organization must submit to the Sec-
9 retary a petition to construct a modular compo-
10 nent health care facility in the Indian commu-
11 nity of the Indian tribe, at such time, in such
12 manner, and containing such information as the
13 Secretary may require.

14 “(2) SELECTION.—In selecting the location of
15 each modular component health care facility to be
16 provided under the demonstration program, the Sec-
17 retary shall give priority to projects already on the
18 Indian Health Service facilities construction priority
19 list and petitions which demonstrate that erection of
20 a modular component health facility—

21 “(A) is more economical than construction
22 of a traditionally constructed health care facil-
23 ity;

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

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

7 “(3) EFFECT OF SELECTION.—A modular com-
8 ponent health care facility project selected for par-
9 ticipation in the demonstration program shall not be
10 eligible for entry on the facilities construction prior-
11 ities list entitled ‘IHS Health Care Facilities FY
12 2011 Planned Construction Budget’ and dated May
13 7, 2009 (or any successor list).

14 “(d) ELIGIBILITY.—

15 “(1) IN GENERAL.—An Indian tribe may sub-
16 mit a petition under subsection (c)(1)(B) regardless
17 of whether the Indian tribe is a party to any con-
18 tract or compact under the Indian Self-Determina-
19 tion and Education Assistance Act (25 U.S.C. 450
20 et seq.).

21 “(2) ADMINISTRATION.—At the election of an
22 Indian tribe or tribal organization selected for par-
23 ticipation in the demonstration program, the funds
24 provided for the project shall be subject to the provi-

1 sions of the Indian Self-Determination and Edu-
2 cation Assistance Act.

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

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

10 “(2) the potential benefits of increased use of
11 modular component health care facilities in other In-
12 dian communities.

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

18 **SEC. 147. MOBILE HEALTH STATIONS DEMONSTRATION**
19 **PROGRAM.**

20 Title III of the Indian Health Care Improvement Act
21 (25 U.S.C. 1631 et seq.) (as amended by section 146) is
22 amended by adding at the end the following:

23 **“SEC. 313. MOBILE HEALTH STATIONS DEMONSTRATION**
24 **PROGRAM.**

25 “(a) DEFINITIONS.—In this section:

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

9 “(2) MOBILE HEALTH STATION.—The term
10 ‘mobile health station’ means a health care unit
11 that—

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

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

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

19 “(3) SPECIALTY HEALTH CARE SERVICE.—

20 “(A) IN GENERAL.—The term ‘specialty
21 health care service’ means a health care service
22 which requires the services of a health care pro-
23 fessional with specialized knowledge or experi-
24 ence.

1 “(B) INCLUSIONS.—The term ‘specialty
2 health care service’ includes any service relating
3 to—

4 “(i) dialysis;

5 “(ii) surgery;

6 “(iii) mammography;

7 “(iv) dentistry; or

8 “(v) any other specialty health care
9 service.

10 “(b) ESTABLISHMENT.—The Secretary, acting
11 through the Service, shall establish a demonstration pro-
12 gram under which the Secretary shall provide at least 3
13 mobile health station projects.

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

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

20 “(2) a description of the specialty service or
21 services for which the mobile health station is re-
22 quested and the extent to which such service or serv-
23 ices are currently available to the Indian population
24 to be served; and

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

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

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

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

13 “(2) to employ an existing mobile health station
14 (regardless of whether the mobile health station is
15 owned or rented and operated by the Service) to pro-
16 vide specialty health care services to an eligible trib-
17 al consortium; and

18 “(3) to establish, purchase, or maintain docking
19 equipment for a mobile health station, including the
20 establishment or maintenance of such equipment at
21 a modular component health care facility (as defined
22 in section 312(a)), if applicable.

23 “(e) REPORTS.—Not later than 1 year after the date
24 on which the demonstration program is established under
25 subsection (b) and annually thereafter, the Secretary, act-

1 ing through the Service, shall submit to Congress a report
2 describing—

3 “(1) each activity carried out under the dem-
4 onstration program including an evaluation of the
5 success of the activity; and

6 “(2) the potential benefits of increased use of
7 mobile health stations to provide specialty health
8 care services for Indian communities.

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

14 **Subtitle D—Access to Health** 15 **Services**

16 **SEC. 151. TREATMENT OF PAYMENTS UNDER SOCIAL SECU-** 17 **RITY ACT HEALTH BENEFITS PROGRAMS.**

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

20 **“SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SE-** 21 **CURITY ACT HEALTH BENEFITS PROGRAMS.**

22 “(a) DISREGARD OF MEDICARE, MEDICAID, AND
23 CHIP PAYMENTS IN DETERMINING APPROPRIATIONS.—
24 Any payments received by an Indian health program or
25 by an urban Indian organization under title XVIII, XIX,

1 or XXI of the Social Security Act for services provided
2 to Indians eligible for benefits under such respective titles
3 shall not be considered in determining appropriations for
4 the provision of health care and services to Indians.

5 “(b) NONPREFERENTIAL TREATMENT.—Nothing in
6 this Act authorizes the Secretary to provide services to an
7 Indian with coverage under title XVIII, XIX, or XI of the
8 Social Security Act in preference to an Indian without
9 such coverage.

10 “(c) USE OF FUNDS.—

11 “(1) SPECIAL FUND.—

12 “(A) 100 PERCENT PASS-THROUGH OF
13 PAYMENTS DUE TO FACILITIES.—Notwith-
14 standing any other provision of law, but subject
15 to paragraph (2), payments to which a facility
16 of the Service is entitled by reason of a provi-
17 sion of title XVIII or XIX of the Social Secu-
18 rity Act shall be placed in a special fund to be
19 held by the Secretary. In making payments
20 from such fund, the Secretary shall ensure that
21 each Service unit of the Service receives 100
22 percent of the amount to which the facilities of
23 the Service, for which such Service unit makes
24 collections, are entitled by reason of a provision
25 of either such title.

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

21 “(2) DIRECT PAYMENT OPTION.—Paragraph
22 (1) shall not apply to a tribal health program upon
23 the election of such program under subsection (d) to
24 receive payments directly. No payment may be made
25 out of the special fund described in such paragraph

1 with respect to reimbursement made for services
2 provided by such program during the period of such
3 election.

4 “(d) DIRECT BILLING.—

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

12 “(2) DIRECT REIMBURSEMENT.—

13 “(A) USE OF FUNDS.—Each tribal health
14 program making the election described in para-
15 graph (1) with respect to a program under a
16 title of the Social Security Act shall be reim-
17 bursed directly by that program for items and
18 services furnished without regard to subsection
19 (c)(1), except that all amounts so reimbursed
20 shall be used by the tribal health program for
21 the purpose of making any improvements in fa-
22 cilities of the tribal health program that may be
23 necessary to achieve or maintain compliance
24 with the conditions and requirements applicable
25 generally to such items and services under the

1 program under such title and to provide addi-
2 tional health care services, improvements in
3 health care facilities and tribal health pro-
4 grams, any health care-related purpose (includ-
5 ing coverage for a service or service within a
6 contract health service delivery area or any por-
7 tion of a contract health service delivery area
8 that would otherwise be provided as a contract
9 health service), or otherwise to achieve the ob-
10 jectives provided in section 3 of this Act.

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

24 “(C) IDENTIFICATION OF SOURCE OF PAY-
25 MENTS.—Any tribal health program that re-

1 ceives reimbursements or payments under title
2 XVIII, XIX, or XXI of the Social Security Act
3 shall provide to the Service a list of each pro-
4 vider enrollment number (or other identifier)
5 under which such program receives such reim-
6 bursements or payments.

7 “(3) EXAMINATION AND IMPLEMENTATION OF
8 CHANGES.—

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

21 “(B) COORDINATION OF INFORMATION.—
22 The Service shall provide the Administrator of
23 the Centers for Medicare & Medicaid Services
24 with copies of the lists submitted to the Service
25 under paragraph (2)(C), enrollment data re-

1 garding patients served by the Service (and by
2 tribal health programs, to the extent such data
3 is available to the Service), and such other in-
4 formation as the Administrator may require for
5 purposes of administering title XVIII, XIX, or
6 XXI of the Social Security Act.

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

20 “(5) TERMINATION FOR FAILURE TO COMPLY
21 WITH REQUIREMENTS.—The Secretary may termi-
22 nate the participation of a tribal health program or
23 in the direct billing program established under this
24 subsection if the Secretary determines that the pro-
25 gram has failed to comply with the requirements of

1 paragraph (2). The Secretary shall provide a tribal
2 health program with notice of a determination that
3 the program has failed to comply with any such re-
4 quirement and a reasonable opportunity to correct
5 such noncompliance prior to terminating the pro-
6 gram's participation in the direct billing program es-
7 tablished under this subsection.

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

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

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

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

16 “(a) IN GENERAL.—Insofar as amounts are made
17 available under law (including a provision of the Social
18 Security Act, the Indian Self-Determination and Edu-
19 cation Assistance Act (25 U.S.C. 450 et seq.), or other
20 law, other than under section 404) to Indian tribes, tribal
21 organizations, and urban Indian organizations for health
22 benefits for Service beneficiaries, Indian tribes, tribal or-
23 ganizations, and urban Indian organizations may use such
24 amounts to purchase health benefits coverage (including
25 coverage for a service, or service within a contract health

1 service delivery area, or any portion of a contract health
2 service delivery area that would otherwise be provided as
3 a contract health service) for such beneficiaries in any
4 manner, including through—

5 “(1) a tribally owned and operated health care
6 plan;

7 “(2) a State or locally authorized or licensed
8 health care plan;

9 “(3) a health insurance provider or managed
10 care organization;

11 “(4) a self-insured plan; or

12 “(5) a high deductible or health savings account
13 plan.

14 “(b) FINANCIAL NEED.—The purchase of coverage
15 under subsection (a) by an Indian tribe, tribal organiza-
16 tion, or urban Indian organization may be based on the
17 financial needs of such beneficiaries (as determined by the
18 1 or more Indian tribes being served based on a schedule
19 of income levels developed or implemented by such 1 or
20 more Indian tribes).

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

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

4 **SEC. 153. GRANTS TO AND CONTRACTS WITH THE SERVICE,**
5 **INDIAN TRIBES, TRIBAL ORGANIZATIONS,**
6 **AND URBAN INDIAN ORGANIZATIONS TO FA-**
7 **CILITATE OUTREACH, ENROLLMENT, AND**
8 **COVERAGE OF INDIANS UNDER SOCIAL SECU-**
9 **RITY ACT HEALTH BENEFIT PROGRAMS AND**
10 **OTHER HEALTH BENEFITS PROGRAMS.**

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

13 **“SEC. 404. GRANTS TO AND CONTRACTS WITH THE SERV-**
14 **ICE, INDIAN TRIBES, TRIBAL ORGANIZA-**
15 **TIONS, AND URBAN INDIAN ORGANIZATIONS**
16 **TO FACILITATE OUTREACH, ENROLLMENT,**
17 **AND COVERAGE OF INDIANS UNDER SOCIAL**
18 **SECURITY ACT HEALTH BENEFIT PROGRAMS**
19 **AND OTHER HEALTH BENEFITS PROGRAMS.**

20 “(a) INDIAN TRIBES AND TRIBAL ORGANIZA-
21 TIONS.—The Secretary, acting through the Service, shall
22 make grants to or enter into contracts with Indian tribes
23 and tribal organizations to assist such tribes and tribal
24 organizations in establishing and administering programs
25 on or near reservations and trust lands, including pro-

1 grams to provide outreach and enrollment through video,
2 electronic delivery methods, or telecommunication devices
3 that allow real-time or time-delayed communication be-
4 tween individual Indians and the benefit program, to as-
5 sist individual Indians—

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

10 “(2) with respect to such programs for which
11 the charging of premiums and cost sharing is not
12 prohibited under such programs, to pay premiums or
13 cost sharing for coverage for such benefits, which
14 may be based on financial need (as determined by
15 the Indian tribe or tribes or tribal organizations
16 being served based on a schedule of income levels de-
17 veloped or implemented by such tribe, tribes, or trib-
18 al organizations).

19 “(b) CONDITIONS.—The Secretary, acting through
20 the Service, shall place conditions as deemed necessary to
21 effect the purpose of this section in any grant or contract
22 which the Secretary makes with any Indian tribe or tribal
23 organization pursuant to this section. Such conditions
24 shall include requirements that the Indian tribe or tribal
25 organization successfully undertake—

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

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

5 “(3) to provide transportation for such indi-
6 vidual Indians to the appropriate offices for enroll-
7 ment or applications for such benefits; and

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

11 “(c) APPLICATION TO URBAN INDIAN ORGANIZA-
12 TIONS.—

13 “(1) IN GENERAL.—The provisions of sub-
14 section (a) shall apply with respect to grants and
15 other funding to urban Indian organizations with re-
16 spect to populations served by such organizations in
17 the same manner they apply to grants and contracts
18 with Indian tribes and tribal organizations with re-
19 spect to programs on or near reservations.

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

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

1 “(B) appropriate to urban Indian organi-
2 zations and urban Indians; and

3 “(C) necessary to effect the purposes of
4 this section.

5 “(d) FACILITATING COOPERATION.—The Secretary,
6 acting through the Centers for Medicare & Medicaid Serv-
7 ices, shall develop and disseminate best practices that will
8 serve to facilitate cooperation with, and agreements be-
9 tween, States and the Service, Indian tribes, tribal organi-
10 zations, or urban Indian organizations with respect to the
11 provision of health care items and services to Indians
12 under the programs established under title XVIII, XIX,
13 or XXI of the Social Security Act.

14 “(e) AGREEMENTS RELATING TO IMPROVING EN-
15 ROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT
16 HEALTH BENEFITS PROGRAMS.—For provisions relating
17 to agreements of the Secretary, acting through the Serv-
18 ice, for the collection, preparation, and submission of ap-
19 plications by Indians for assistance under the Medicaid
20 and children’s health insurance programs established
21 under titles XIX and XXI of the Social Security Act, and
22 benefits under the Medicare program established under
23 title XVIII of such Act, see subsections (a) and (b) of sec-
24 tion 1139 of the Social Security Act.

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

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

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

8 **SEC. 154. SHARING ARRANGEMENTS WITH FEDERAL AGEN-**
9 **CIES.**

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

12 **“SEC. 405. SHARING ARRANGEMENTS WITH FEDERAL AGEN-**
13 **CIES.**

14 “(a) AUTHORITY.—

15 “(1) IN GENERAL.—The Secretary may enter
16 into (or expand) arrangements for the sharing of
17 medical facilities and services between the Service,
18 Indian tribes, and tribal organizations and the De-
19 partment of Veterans Affairs and the Department of
20 Defense.

21 “(2) CONSULTATION BY SECRETARY RE-
22 QUIRED.—The Secretary may not finalize any ar-
23 rangement between the Service and a Department
24 described in paragraph (1) without first consulting

1 with the Indian tribes which will be significantly af-
2 fected by the arrangement.

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

7 “(1) the priority access of any Indian to health
8 care services provided through the Service and the
9 eligibility of any Indian to receive health services
10 through the Service;

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

13 “(3) the priority access of any veteran to health
14 care services provided by the Department of Vet-
15 erans Affairs;

16 “(4) the quality of health care services provided
17 by the Department of Veterans Affairs or the De-
18 partment of Defense; or

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

22 “(c) REIMBURSEMENT.—The Service, Indian tribe,
23 or tribal organization shall be reimbursed by the Depart-
24 ment of Veterans Affairs or the Department of Defense
25 (as the case may be) where services are provided through

1 the Service, an Indian tribe, or a tribal organization to
 2 beneficiaries eligible for services from either such Depart-
 3 ment, notwithstanding any other provision of law.

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

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

8 Title IV of the Indian Health Care Improvement Act
 9 (25 U.S.C. 1641 et seq.) (as amended by section 101(b))
 10 is amended by adding at the end the following:

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

12 “(a) FINDINGS; PURPOSE.—

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

14 “(A) collaborations between the Secretary
 15 and the Secretary of Veterans Affairs regarding
 16 the treatment of Indian veterans at facilities of
 17 the Service should be encouraged to the max-
 18 imum extent practicable; and

19 “(B) increased enrollment for services of
 20 the Department of Veterans Affairs by veterans
 21 who are members of Indian tribes should be en-
 22 couraged to the maximum extent practicable.

23 “(2) PURPOSE.—The purpose of this section is
 24 to reaffirm the goals stated in the document entitled
 25 ‘Memorandum of Understanding Between the VA/

1 Veterans Health Administration And HHS/Indian
2 Health Service’ and dated February 25, 2003 (relat-
3 ing to cooperation and resource sharing between the
4 Veterans Health Administration and Service).

5 “(b) DEFINITIONS.—In this section:

6 “(1) ELIGIBLE INDIAN VETERAN.—The term
7 ‘eligible Indian veteran’ means an Indian or Alaska
8 Native veteran who receives any medical service that
9 is—

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

12 “(B) administered at a facility of the Serv-
13 ice (including a facility operated by an Indian
14 tribe or tribal organization through a contract
15 or compact with the Service under the Indian
16 Self-Determination and Education Assistance
17 Act (25 U.S.C. 450 et seq.)) pursuant to a local
18 memorandum of understanding.

19 “(2) LOCAL MEMORANDUM OF UNDER-
20 STANDING.—The term ‘local memorandum of under-
21 standing’ means a memorandum of understanding
22 between the Secretary (or a designee, including the
23 director of any area office of the Service) and the
24 Secretary of Veterans Affairs (or a designee) to im-
25 plement the document entitled ‘Memorandum of Un-

1 derstanding Between the VA/Veterans Health Ad-
2 ministration And HHS/Indian Health Service’ and
3 dated February 25, 2003 (relating to cooperation
4 and resource sharing between the Veterans Health
5 Administration and Indian Health Service).

6 “(c) ELIGIBLE INDIAN VETERANS EXPENSES.—

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

11 “(2) METHOD OF PAYMENT.—The Secretary
12 shall establish such guidelines as the Secretary de-
13 termines to be appropriate regarding the method of
14 payments to the Secretary of Veterans Affairs under
15 paragraph (1).

16 “(d) TRIBAL APPROVAL OF MEMORANDA.—In nego-
17 tiating a local memorandum of understanding with the
18 Secretary of Veterans Affairs regarding the provision of
19 services to eligible Indian veterans, the Secretary shall
20 consult with each Indian tribe that would be affected by
21 the local memorandum of understanding.

22 “(e) FUNDING.—

23 “(1) TREATMENT.—Expenses incurred by the
24 Secretary in carrying out subsection (c)(1) shall not

1 be considered to be Contract Health Service ex-
 2 penses.

3 “(2) USE OF FUNDS.—Of funds made available
 4 to the Secretary in appropriations Acts for the Serv-
 5 ice (excluding funds made available for facilities,
 6 Contract Health Services, or contract support costs),
 7 the Secretary shall use such sums as are necessary
 8 to carry out this section.”.

9 **SEC. 156. NONDISCRIMINATION UNDER FEDERAL HEALTH**
 10 **CARE PROGRAMS IN QUALIFICATIONS FOR**
 11 **REIMBURSEMENT FOR SERVICES.**

12 Title IV of the Indian Health Care Improvement Act
 13 (25 U.S.C. 1641 et seq.) (as amended by section 155) is
 14 amended by adding at the end the following:

15 **“SEC. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH**
 16 **CARE PROGRAMS IN QUALIFICATIONS FOR**
 17 **REIMBURSEMENT FOR SERVICES.**

18 “(a) REQUIREMENT TO SATISFY GENERALLY APPLI-
 19 CABLE PARTICIPATION REQUIREMENTS.—

20 “(1) IN GENERAL.—A Federal health care pro-
 21 gram must accept an entity that is operated by the
 22 Service, an Indian tribe, tribal organization, or
 23 urban Indian organization as a provider eligible to
 24 receive payment under the program for health care
 25 services furnished to an Indian on the same basis as

1 any other provider qualified to participate as a pro-
2 vider of health care services under the program if
3 the entity meets generally applicable State or other
4 requirements for participation as a provider of
5 health care services under the program.

6 “(2) SATISFACTION OF STATE OR LOCAL LICEN-
7 SURE OR RECOGNITION REQUIREMENTS.—Any re-
8 quirement for participation as a provider of health
9 care services under a Federal health care program
10 that an entity be licensed or recognized under the
11 State or local law where the entity is located to fur-
12 nish health care services shall be deemed to have
13 been met in the case of an entity operated by the
14 Service, an Indian tribe, tribal organization, or
15 urban Indian organization if the entity meets all the
16 applicable standards for such licensure or recogni-
17 tion, regardless of whether the entity obtains a li-
18 cense or other documentation under such State or
19 local law. In accordance with section 221, the ab-
20 sence of the licensure of a health professional em-
21 ployed by such an entity under the State or local law
22 where the entity is located shall not be taken into
23 account for purposes of determining whether the en-
24 tity meets such standards, if the professional is li-
25 censed in another State.

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

3 “(1) EXCLUDED ENTITIES.—No entity operated
4 by the Service, an Indian tribe, tribal organization,
5 or urban Indian organization that has been excluded
6 from participation in any Federal health care pro-
7 gram or for which a license is under suspension or
8 has been revoked by the State where the entity is lo-
9 cated shall be eligible to receive payment or reim-
10 bursement under any such program for health care
11 services furnished to an Indian.

12 “(2) EXCLUDED INDIVIDUALS.—No individual
13 who has been excluded from participation in any
14 Federal health care program or whose State license
15 is under suspension shall be eligible to receive pay-
16 ment or reimbursement under any such program for
17 health care services furnished by that individual, di-
18 rectly or through an entity that is otherwise eligible
19 to receive payment for health care services, to an In-
20 dian.

21 “(3) FEDERAL HEALTH CARE PROGRAM DE-
22 FINED.—In this subsection, the term, ‘Federal
23 health care program’ has the meaning given that
24 term in section 1128B(f) of the Social Security Act
25 (42 U.S.C. 1320a–7b(f)), except that, for purposes

1 of this subsection, such term shall include the health
2 insurance program under chapter 89 of title 5,
3 United States Code.

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

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

10 Title IV of the Indian Health Care Improvement Act
11 (25 U.S.C. 1641 et seq.) (as amended by section 156) is
12 amended by adding at the end the following:

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

14 “Notwithstanding the provisions of title 5, United
15 States Code, Executive order, or administrative regula-
16 tion, an Indian tribe or tribal organization carrying out
17 programs under the Indian Self-Determination and Edu-
18 cation Assistance Act (25 U.S.C. 450 et seq.) or an urban
19 Indian organization carrying out programs under title V
20 of this Act shall be entitled to purchase coverage, rights,
21 and benefits for the employees of such Indian tribe or trib-
22 al organization, or urban Indian organization, under chap-
23 ter 89 of title 5, United States Code, and chapter 87 of
24 such title if necessary employee deductions and agency
25 contributions in payment for the coverage, rights, and ben-

1 efits for the period of employment with such Indian tribe
 2 or tribal organization, or urban Indian organization, are
 3 currently deposited in the applicable Employee’s Fund
 4 under such title.”.

5 **SEC. 158. GENERAL EXCEPTIONS.**

6 Title IV of the Indian Health Care Improvement Act
 7 (25 U.S.C. 1641 et seq.) (as amended by section 157) is
 8 amended by adding at the end the following:

9 **“SEC. 410. GENERAL EXCEPTIONS.**

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

14 **SEC. 159. NAVAJO NATION MEDICAID AGENCY FEASIBILITY**
 15 **STUDY.**

16 Title IV of the Indian Health Care Improvement Act
 17 (25 U.S.C. 1641 et seq.) (as amended by section 158) is
 18 amended by adding at the end the following:

19 **“SEC. 411. NAVAJO NATION MEDICAID AGENCY FEASI-**
 20 **BILITY STUDY.**

21 “(a) STUDY.—The Secretary shall conduct a study
 22 to determine the feasibility of treating the Navajo Nation
 23 as a State for the purposes of title XIX of the Social Secu-
 24 rity Act, to provide services to Indians living within the
 25 boundaries of the Navajo Nation through an entity estab-

1 lished having the same authority and performing the same
2 functions as single-State medicaid agencies responsible for
3 the administration of the State plan under title XIX of
4 the Social Security Act.

5 “(b) CONSIDERATIONS.—In conducting the study,
6 the Secretary shall consider the feasibility of—

7 “(1) assigning and paying all expenditures for
8 the provision of services and related administration
9 funds, under title XIX of the Social Security Act, to
10 Indians living within the boundaries of the Navajo
11 Nation that are currently paid to or would otherwise
12 be paid to the State of Arizona, New Mexico, or
13 Utah;

14 “(2) providing assistance to the Navajo Nation
15 in the development and implementation of such enti-
16 ty for the administration, eligibility, payment, and
17 delivery of medical assistance under title XIX of the
18 Social Security Act;

19 “(3) providing an appropriate level of matching
20 funds for Federal medical assistance with respect to
21 amounts such entity expends for medical assistance
22 for services and related administrative costs; and

23 “(4) authorizing the Secretary, at the option of
24 the Navajo Nation, to treat the Navajo Nation as a
25 State for the purposes of title XIX of the Social Se-

1 security Act (relating to the State children’s health in-
2 surance program) under terms equivalent to those
3 described in paragraphs (2) through (4).

4 “(c) REPORT.—Not later than 3 years after the date
5 of enactment of the Indian Healthcare Improvement Act
6 of 2017, the Secretary shall submit to the Committee on
7 Indian Affairs and Committee on Finance of the Senate
8 and the Committee on Natural Resources and Committee
9 on Energy and Commerce of the House of Representatives
10 a report that includes—

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

12 “(2) a summary of any consultation that oc-
13 curred between the Secretary and the Navajo Na-
14 tion, other Indian Tribes, the States of Arizona,
15 New Mexico, and Utah, counties which include Nav-
16 ajo Lands, and other interested parties, in con-
17 ducting this study;

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

22 “(4) legislative actions that would be required
23 to authorize the establishment of such entity if such
24 entity is determined by the Secretary to be fea-
25 sible.”.

1 **Subtitle E—Health Services for**
2 **Urban Indians**

3 **SEC. 161. FACILITIES RENOVATION.**

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

8 **SEC. 162. TREATMENT OF CERTAIN DEMONSTRATION**
9 **PROJECTS.**

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

12 **“SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION**
13 **PROJECTS.**

14 “Notwithstanding any other provision of law, the
15 Tulsa Clinic and Oklahoma City Clinic demonstration
16 projects shall—

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

19 “(2) continue to be treated as Service units and
20 operating units in the allocation of resources and co-
21 ordination of care; and

22 “(3) continue to meet the requirements and
23 definitions of an urban Indian organization in this
24 Act, and shall not be subject to the provisions of the

1 Indian Self-Determination and Education Assistance
2 Act (25 U.S.C. 450 et seq.).”.

3 **SEC. 163. REQUIREMENT TO CONFER WITH URBAN INDIAN**
4 **ORGANIZATIONS.**

5 (a) CONFERRING WITH URBAN INDIAN ORGANIZA-
6 TIONS.—Title V of the Indian Health Care Improvement
7 Act (25 U.S.C. 1651 et seq.) (as amended by section
8 101(b)) is amended by adding at the end the following:

9 **“SEC. 514. CONFERRING WITH URBAN INDIAN ORGANIZA-**
10 **TIONS.**

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

14 “(1) leads to mutual understanding and com-
15 prehension; and

16 “(2) emphasizes trust, respect, and shared re-
17 sponsibility.

18 “(b) REQUIREMENT.—The Secretary shall ensure
19 that the Service confers, to the maximum extent prac-
20 ticable, with urban Indian organizations in carrying out
21 this Act.”.

22 (b) CONTRACTS WITH, AND GRANTS TO, URBAN IN-
23 DIAN ORGANIZATIONS.—Section 502 of the Indian Health
24 Care Improvement Act (25 U.S.C. 1652) is amended to
25 read as follows:

1 **“SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN IN-**
2 **DIAN ORGANIZATIONS.**

3 “(a) IN GENERAL.—Pursuant to the Act of Novem-
4 ber 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Sny-
5 der Act’), the Secretary, acting through the Service, shall
6 enter into contracts with, or make grants to, urban Indian
7 organizations to assist the urban Indian organizations in
8 the establishment and administration, within urban cen-
9 ters, of programs that meet the requirements of this title.

10 “(b) CONDITIONS.—Subject to section 506, the Sec-
11 retary, acting through the Service, shall include such con-
12 ditions as the Secretary considers necessary to effect the
13 purpose of this title in any contract into which the Sec-
14 retary enters with, or in any grant the Secretary makes
15 to, any urban Indian organization pursuant to this title.”.

16 **SEC. 164. EXPANDED PROGRAM AUTHORITY FOR URBAN IN-**
17 **DIAN ORGANIZATIONS.**

18 Title V of the Indian Health Care Improvement Act
19 (25 U.S.C. 1651 et seq.) (as amended by section 163(a))
20 is amended by adding at the end the following:

21 **“SEC. 515. EXPANDED PROGRAM AUTHORITY FOR URBAN**
22 **INDIAN ORGANIZATIONS.**

23 “Notwithstanding any other provision of this Act, the
24 Secretary, acting through the Service, is authorized to es-
25 tablish programs, including programs for awarding grants,
26 for urban Indian organizations that are identical to any

1 programs established pursuant to sections 218, 702, and
2 708(g).”.

3 **SEC. 165. COMMUNITY HEALTH REPRESENTATIVES.**

4 Title V of the Indian Health Care Improvement Act
5 (25 U.S.C. 1651 et seq.) (as amended by section 164) is
6 amended by adding at the end the following:

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

8 “The Secretary, acting through the Service, may
9 enter into contracts with, and make grants to, urban In-
10 dian organizations for the employment of Indians trained
11 as health service providers through the Community Health
12 Representative Program under section 107 in the provi-
13 sion of health care, health promotion, and disease preven-
14 tion services to urban Indians.”.

15 **SEC. 166. USE OF FEDERAL GOVERNMENT FACILITIES AND**
16 **SOURCES OF SUPPLY; HEALTH INFORMATION**
17 **TECHNOLOGY.**

18 Title V of the Indian Health Care Improvement Act
19 (25 U.S.C. 1651 et seq.) (as amended by section 165) is
20 amended by adding at the end the following:

21 **“SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND**
22 **SOURCES OF SUPPLY.**

23 “(a) IN GENERAL.—The Secretary may permit an
24 urban Indian organization that has entered into a contract
25 or received a grant pursuant to this title, in carrying out

1 the contract or grant, to use, in accordance with such
2 terms and conditions for use and maintenance as are
3 agreed on by the Secretary and the urban Indian organiza-
4 tions—

5 “(1) any existing facility under the jurisdiction
6 of the Secretary;

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

9 “(3) any other personal property of the Federal
10 Government under the jurisdiction of the Secretary.

11 “(b) DONATIONS.—Subject to subsection (d), the
12 Secretary may donate to an urban Indian organization
13 that has entered into a contract or received a grant pursu-
14 ant to this title any personal or real property determined
15 to be excess to the needs of the Service or the General
16 Services Administration for the purposes of carrying out
17 the contract or grant.

18 “(c) ACQUISITION OF PROPERTY.—The Secretary
19 may acquire excess or surplus personal or real property
20 of the Federal Government for donation, subject to sub-
21 section (d), to an urban Indian organization that has en-
22 tered into a contract or received a grant pursuant to this
23 title if the Secretary determines that the property is ap-
24 propriate for use by the urban Indian organization for
25 purposes of the contract or grant.

1 “(d) PRIORITY.—If the Secretary receives from an
2 urban Indian organization or an Indian tribe or tribal or-
3 ganization a request for a specific item of personal or real
4 property described in subsection (b) or (c), the Secretary
5 shall give priority to the request for donation to the Indian
6 tribe or tribal organization, if the Secretary receives the
7 request from the Indian tribe or tribal organization before
8 the earlier of—

9 “(1) the date on which the Secretary transfers
10 title to the property to the urban Indian organiza-
11 tion; and

12 “(2) the date on which the Secretary transfers
13 the property physically to the urban Indian organi-
14 zation.

15 “(e) EXECUTIVE AGENCY STATUS.—For purposes of
16 section 501(a) of title 40, United States Code, an urban
17 Indian organization that has entered into a contract or
18 received a grant pursuant to this title may be considered
19 to be an Executive agency in carrying out the contract
20 or grant.

21 **“SEC. 518. HEALTH INFORMATION TECHNOLOGY.**

22 “The Secretary, acting through the Service, may
23 make grants to urban Indian organizations under this title
24 for the development, adoption, and implementation of
25 health information technology (as defined in section 3000

1 of the Public Health Service Act (42 U.S.C. 300jj)), tele-
2 medicine services development, and related infrastruc-
3 ture.”.

4 **Subtitle F—Organizational** 5 **Improvements**

6 **SEC. 171. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
7 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
8 **SERVICE.**

9 Section 601 of the Indian Health Care Improvement
10 Act (25 U.S.C. 1661) is amended to read as follows:

11 **“SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERV-**
12 **ICE AS AN AGENCY OF THE PUBLIC HEALTH**
13 **SERVICE.**

14 “(a) ESTABLISHMENT.—

15 “(1) IN GENERAL.—In order to more effectively
16 and efficiently carry out the responsibilities, authori-
17 ties, and functions of the United States to provide
18 health care services to Indians and Indian tribes, as
19 are or may be hereafter provided by Federal statute
20 or treaties, there is established within the Public
21 Health Service of the Department the Indian Health
22 Service.

23 “(2) DIRECTOR.—The Service shall be adminis-
24 tered by a Director, who shall be appointed by the
25 President, by and with the advice and consent of the

1 Senate. The Director shall report to the Secretary.
2 Effective with respect to an individual appointed by
3 the President, by and with the advice and consent
4 of the Senate, after January 1, 2008, the term of
5 service of the Director shall be 4 years. A Director
6 may serve more than 1 term.

7 “(3) INCUMBENT.—The individual serving in
8 the position of Director of the Service on the day be-
9 fore the date of enactment of the Indian Healthcare
10 Improvement Act of 2017 shall serve as Director.

11 “(4) ADVOCACY AND CONSULTATION.—The po-
12 sition of Director is established to, in a manner con-
13 sistent with the government-to-government relation-
14 ship between the United States and Indian Tribes—

15 “(A) facilitate advocacy for the develop-
16 ment of appropriate Indian health policy; and

17 “(B) promote consultation on matters re-
18 lating to Indian health.

19 “(b) AGENCY.—The Service shall be an agency within
20 the Public Health Service of the Department, and shall
21 not be an office, component, or unit of any other agency
22 of the Department.

23 “(c) DUTIES.—The Director shall—

24 “(1) perform all functions that were, on the day
25 before the date of enactment of the Indian

1 Healthcare Improvement Act of 2017, carried out by
2 or under the direction of the individual serving as
3 Director of the Service on that day;

4 “(2) perform all functions of the Secretary re-
5 lating to the maintenance and operation of hospital
6 and health facilities for Indians and the planning
7 for, and provision and utilization of, health services
8 for Indians, including by ensuring that all agency di-
9 rectors, managers, and chief executive officers have
10 appropriate and adequate training, experience, skill
11 levels, knowledge, abilities, and education (including
12 continuing training requirements) to competently
13 fulfill the duties of the positions and the mission of
14 the Service;

15 “(3) administer all health programs under
16 which health care is provided to Indians based upon
17 their status as Indians which are administered by
18 the Secretary, including programs under—

19 “(A) this Act;

20 “(B) the Act of November 2, 1921 (25
21 U.S.C. 13);

22 “(C) the Act of August 5, 1954 (42 U.S.C.
23 2001 et seq.);

24 “(D) the Act of August 16, 1957 (42
25 U.S.C. 2005 et seq.); and

1 “(E) the Indian Self-Determination and
2 Education Assistance Act (25 U.S.C. 450 et
3 seq.);

4 “(4) administer all scholarship and loan func-
5 tions carried out under title I;

6 “(5) directly advise the Secretary concerning
7 the development of all policy- and budget-related
8 matters affecting Indian health;

9 “(6) collaborate with the Assistant Secretary
10 for Health concerning appropriate matters of Indian
11 health that affect the agencies of the Public Health
12 Service;

13 “(7) advise each Assistant Secretary of the De-
14 partment concerning matters of Indian health with
15 respect to which that Assistant Secretary has au-
16 thority and responsibility;

17 “(8) advise the heads of other agencies and pro-
18 grams of the Department concerning matters of In-
19 dian health with respect to which those heads have
20 authority and responsibility;

21 “(9) coordinate the activities of the Department
22 concerning matters of Indian health; and

23 “(10) perform such other functions as the Sec-
24 retary may designate.

25 “(d) AUTHORITY.—

1 “(1) IN GENERAL.—The Secretary, acting
2 through the Director, shall have the authority—

3 “(A) except to the extent provided for in
4 paragraph (2), to appoint and compensate em-
5 ployees for the Service in accordance with title
6 5, United States Code;

7 “(B) to enter into contracts for the pro-
8 curement of goods and services to carry out the
9 functions of the Service; and

10 “(C) to manage, expend, and obligate all
11 funds appropriated for the Service.

12 “(2) PERSONNEL ACTIONS.—Notwithstanding
13 any other provision of law, the provisions of section
14 12 of the Act of June 18, 1934 (48 Stat. 986; 25
15 U.S.C. 472), shall apply to all personnel actions
16 taken with respect to new positions created within
17 the Service as a result of its establishment under
18 subsection (a).”.

19 **SEC. 172. OFFICE OF DIRECT SERVICE TRIBES.**

20 Title VI of the Indian Health Care Improvement Act
21 (25 U.S.C. 1661 et seq.) (as amended by section 101(b))
22 is amended by adding at the end the following:

1 **“SEC. 603. OFFICE OF DIRECT SERVICE TRIBES.**

2 “(a) ESTABLISHMENT.—There is established within
3 the Service an office, to be known as the ‘Office of Direct
4 Service Tribes’.

5 “(b) TREATMENT.—The Office of Direct Service
6 Tribes shall be located in the Office of the Director.

7 “(c) DUTIES.—The Office of Direct Service Tribes
8 shall be responsible for—

9 “(1) providing Service-wide leadership, guidance
10 and support for direct service tribes to include stra-
11 tegic planning and program evaluation;

12 “(2) ensuring maximum flexibility to tribal
13 health and related support systems for Indian bene-
14 ficiaries;

15 “(3) serving as the focal point for consultation
16 and participation between direct service tribes and
17 organizations and the Service in the development of
18 Service policy;

19 “(4) holding no less than biannual consultations
20 with direct service tribes in appropriate locations to
21 gather information and aid in the development of
22 health policy; and

23 “(5) directing a national program and providing
24 leadership and advocacy in the development of
25 health policy, program management, budget formu-

1 lation, resource allocation, and delegation support
2 for direct service tribes.”.

3 **SEC. 173. NEVADA AREA OFFICE.**

4 Title VI of the Indian Health Care Improvement Act
5 (25 U.S.C. 1661 et seq.) (as amended by section 172) is
6 amended by adding at the end the following:

7 **“SEC. 604. NEVADA AREA OFFICE.**

8 “(a) IN GENERAL.—Not later than 1 year after the
9 date of enactment of this section, in a manner consistent
10 with the tribal consultation policy of the Service, the Sec-
11 retary shall submit to Congress a plan describing the man-
12 ner and schedule by which an area office, separate and
13 distinct from the Phoenix Area Office of the Service, can
14 be established in the State of Nevada.

15 “(b) FAILURE TO SUBMIT PLAN.—

16 “(1) DEFINITION OF OPERATIONS FUNDS.—In
17 this subsection, the term ‘operations funds’ means
18 only the funds used for—

19 “(A) the administration of services, includ-
20 ing functional expenses such as overtime, per-
21 sonnel salaries, and associated benefits; or

22 “(B) related tasks that directly affect the
23 operations described in subparagraph (A).

24 “(2) WITHHOLDING OF FUNDS.—If the Sec-
25 retary fails to submit a plan in accordance with sub-

1 section (a), the Secretary shall withhold the oper-
 2 ations funds reserved for the Office of the Director,
 3 subject to the condition that the withholding shall
 4 not adversely impact the capacity of the Service to
 5 deliver health care services.

6 “(3) RESTORATION.—The operations funds
 7 withheld pursuant to paragraph (2) may be restored,
 8 at the discretion of the Secretary, to the Office of
 9 the Director on achievement by that Office of com-
 10 pliance with this section.”.

11 **Subtitle G—Behavioral Health** 12 **Programs**

13 **SEC. 181. BEHAVIORAL HEALTH PROGRAMS.**

14 Title VII of the Indian Health Care Improvement Act
 15 (25 U.S.C. 1665 et seq.) is amended to read as follows:

16 **“TITLE VII—BEHAVIORAL** 17 **HEALTH PROGRAMS**

18 **“Subtitle A—General Programs**

19 **“SEC. 701. DEFINITIONS.**

20 “In this subtitle:

21 “(1) **ALCOHOL-RELATED**
 22 **NEURODEVELOPMENTAL DISORDERS; ARND.**—The
 23 term ‘alcohol-related neurodevelopmental disorders’
 24 or ‘ARND’ means, with a history of maternal alco-
 25 hol consumption during pregnancy, central nervous

1 system abnormalities, which may range from minor
2 intellectual deficits and developmental delays to
3 mental retardation. ARND children may have behav-
4 ioral problems, learning disabilities, problems with
5 executive functioning, and attention disorders. The
6 neurological defects of ARND may be as severe as
7 FAS, but facial anomalies and other physical char-
8 acteristics are not present in ARND, thus making
9 diagnosis difficult.

10 “(2) ASSESSMENT.—The term ‘assessment’
11 means the systematic collection, analysis, and dis-
12 semination of information on health status, health
13 needs, and health problems.

14 “(3) BEHAVIORAL HEALTH AFTERCARE.—The
15 term ‘behavioral health aftercare’ includes those ac-
16 tivities and resources used to support recovery fol-
17 lowing inpatient, residential, intensive substance
18 abuse, or mental health outpatient or outpatient
19 treatment. The purpose is to help prevent or deal
20 with relapse by ensuring that by the time a client or
21 patient is discharged from a level of care, such as
22 outpatient treatment, an aftercare plan has been de-
23 veloped with the client. An aftercare plan may use
24 such resources as a community-based therapeutic
25 group, transitional living facilities, a 12-step spon-

1 sor, a local 12-step or other related support group,
2 and other community-based providers.

3 “(4) DUAL DIAGNOSIS.—The term ‘dual diag-
4 nosis’ means coexisting substance abuse and mental
5 illness conditions or diagnosis. Such clients are
6 sometimes referred to as mentally ill chemical abus-
7 ers (MICAs).

8 “(5) FETAL ALCOHOL SPECTRUM DIS-
9 ORDERS.—

10 “(A) IN GENERAL.—The term ‘fetal alco-
11 hol spectrum disorders’ includes a range of ef-
12 fects that can occur in an individual whose
13 mother drank alcohol during pregnancy, includ-
14 ing physical, mental, behavioral, and/or learning
15 disabilities with possible lifelong implications.

16 “(B) INCLUSIONS.—The term ‘fetal alcohol
17 spectrum disorders’ may include—

18 “(i) fetal alcohol syndrome (FAS);

19 “(ii) partial fetal alcohol syndrome
20 (partial FAS);

21 “(iii) alcohol-related birth defects
22 (ARBD); and

23 “(iv) alcohol-related
24 neurodevelopmental disorders (ARND).

1 “(6) FAS OR FETAL ALCOHOL SYNDROME.—

2 The term ‘FAS’ or ‘fetal alcohol syndrome’ means a
3 syndrome in which, with a history of maternal alco-
4 hol consumption during pregnancy, the following cri-
5 teria are met:

6 “(A) Central nervous system involvement,
7 such as mental retardation, developmental
8 delay, intellectual deficit, microencephaly, or
9 neurological abnormalities.

10 “(B) Craniofacial abnormalities with at
11 least 2 of the following:

12 “(i) Microphthalmia.

13 “(ii) Short palpebral fissures.

14 “(iii) Poorly developed philtrum.

15 “(iv) Thin upper lip.

16 “(v) Flat nasal bridge.

17 “(vi) Short upturned nose.

18 “(C) Prenatal or postnatal growth delay.

19 “(7) REHABILITATION.—The term ‘rehabilita-
20 tion’ means medical and health care services that—

21 “(A) are recommended by a physician or
22 licensed practitioner of the healing arts within
23 the scope of their practice under applicable law;

1 “(B) are furnished in a facility, home, or
2 other setting in accordance with applicable
3 standards; and

4 “(C) have as their purpose any of the fol-
5 lowing:

6 “(i) The maximum attainment of
7 physical, mental, and developmental func-
8 tioning.

9 “(ii) Averting deterioration in physical
10 or mental functional status.

11 “(iii) The maintenance of physical or
12 mental health functional status.

13 “(8) SUBSTANCE ABUSE.—The term ‘substance
14 abuse’ includes inhalant abuse.

15 **“SEC. 702. BEHAVIORAL HEALTH PREVENTION AND TREAT-**
16 **MENT SERVICES.**

17 “(a) PURPOSES.—The purposes of this section are as
18 follows:

19 “(1) To authorize and direct the Secretary, act-
20 ing through the Service, Indian tribes, and tribal or-
21 ganizations, to develop a comprehensive behavioral
22 health prevention and treatment program which em-
23 phasizes collaboration among alcohol and substance
24 abuse, social services, and mental health programs.

1 “(2) To provide information, direction, and
2 guidance relating to mental illness and dysfunction
3 and self-destructive behavior, including child abuse
4 and family violence, to those Federal, tribal, State,
5 and local agencies responsible for programs in In-
6 dian communities in areas of health care, education,
7 social services, child and family welfare, alcohol and
8 substance abuse, law enforcement, and judicial serv-
9 ices.

10 “(3) To assist Indian tribes to identify services
11 and resources available to address mental illness and
12 dysfunctional and self-destructive behavior.

13 “(4) To provide authority and opportunities for
14 Indian tribes and tribal organizations to develop, im-
15 plement, and coordinate with community-based pro-
16 grams which include identification, prevention, edu-
17 cation, referral, and treatment services, including
18 through multidisciplinary resource teams.

19 “(5) To ensure that Indians, as citizens of the
20 United States and of the States in which they re-
21 side, have the same access to behavioral health serv-
22 ices to which all citizens have access.

23 “(6) To modify or supplement existing pro-
24 grams and authorities in the areas identified in
25 paragraph (2).

1 “(b) PLANS.—

2 “(1) DEVELOPMENT.—The Secretary, acting
3 through the Service, Indian tribes, and tribal organi-
4 zations, shall encourage Indian tribes and tribal or-
5 ganizations to develop tribal plans, and urban Indian
6 organizations to develop local plans, and for all such
7 groups to participate in developing areawide plans
8 for Indian Behavioral Health Services. The plans
9 shall include, to the extent feasible, the following
10 components:

11 “(A) An assessment of the scope of alcohol
12 or other substance abuse, mental illness, and
13 dysfunctional and self-destructive behavior, in-
14 cluding suicide, child abuse, and family vio-
15 lence, among Indians, including—

16 “(i) the number of Indians served who
17 are directly or indirectly affected by such
18 illness or behavior; or

19 “(ii) an estimate of the financial and
20 human cost attributable to such illness or
21 behavior.

22 “(B) An assessment of the existing and
23 additional resources necessary for the preven-
24 tion and treatment of such illness and behavior,
25 including an assessment of the progress toward

1 achieving the availability of the full continuum
2 of care described in subsection (c).

3 “(C) An estimate of the additional funding
4 needed by the Service, Indian tribes, tribal or-
5 ganizations, and urban Indian organizations to
6 meet their responsibilities under the plans.

7 “(2) NATIONAL CLEARINGHOUSE.—The Sec-
8 retary, acting through the Service, shall coordinate
9 with existing national clearinghouses and informa-
10 tion centers to include at the clearinghouses and
11 centers plans and reports on the outcomes of such
12 plans developed by Indian tribes, tribal organiza-
13 tions, urban Indian organizations, and Service areas
14 relating to behavioral health. The Secretary shall en-
15 sure access to these plans and outcomes by any In-
16 dian tribe, tribal organization, urban Indian organi-
17 zation, or the Service.

18 “(3) TECHNICAL ASSISTANCE.—The Secretary
19 shall provide technical assistance to Indian tribes,
20 tribal organizations, and urban Indian organizations
21 in preparation of plans under this section and in de-
22 veloping standards of care that may be used and
23 adopted locally.

1 “(c) PROGRAMS.—The Secretary, acting through the
2 Service, shall provide, to the extent feasible and if funding
3 is available, programs including the following:

4 “(1) COMPREHENSIVE CARE.—A comprehensive
5 continuum of behavioral health care which pro-
6 vides—

7 “(A) community-based prevention, inter-
8 vention, outpatient, and behavioral health
9 aftercare;

10 “(B) detoxification (social and medical);

11 “(C) acute hospitalization;

12 “(D) intensive outpatient/day treatment;

13 “(E) residential treatment;

14 “(F) transitional living for those needing a
15 temporary, stable living environment that is
16 supportive of treatment and recovery goals;

17 “(G) emergency shelter;

18 “(H) intensive case management;

19 “(I) diagnostic services; and

20 “(J) promotion of healthy approaches to
21 risk and safety issues, including injury preven-
22 tion.

23 “(2) CHILD CARE.—Behavioral health services
24 for Indians from birth through age 17, including—

1 “(A) preschool and school age fetal alcohol
2 spectrum disorder services, including assess-
3 ment and behavioral intervention;

4 “(B) mental health and substance abuse
5 services (emotional, organic, alcohol, drug, in-
6 halant, and tobacco);

7 “(C) identification and treatment of co-oc-
8 curring disorders and comorbidity;

9 “(D) prevention of alcohol, drug, inhalant,
10 and tobacco use;

11 “(E) early intervention, treatment, and
12 aftercare;

13 “(F) promotion of healthy approaches to
14 risk and safety issues; and

15 “(G) identification and treatment of ne-
16 glect and physical, mental, and sexual abuse.

17 “(3) ADULT CARE.—Behavioral health services
18 for Indians from age 18 through 55, including—

19 “(A) early intervention, treatment, and
20 aftercare;

21 “(B) mental health and substance abuse
22 services (emotional, alcohol, drug, inhalant, and
23 tobacco), including sex specific services;

1 “(C) identification and treatment of co-oc-
2 curring disorders (dual diagnosis) and comor-
3 bidity;

4 “(D) promotion of healthy approaches for
5 risk-related behavior;

6 “(E) treatment services for women at risk
7 of giving birth to a child with a fetal alcohol
8 spectrum disorder; and

9 “(F) sex specific treatment for sexual as-
10 sault and domestic violence.

11 “(4) FAMILY CARE.—Behavioral health services
12 for families, including—

13 “(A) early intervention, treatment, and
14 aftercare for affected families;

15 “(B) treatment for sexual assault and do-
16 mestic violence; and

17 “(C) promotion of healthy approaches re-
18 lating to parenting, domestic violence, and other
19 abuse issues.

20 “(5) ELDER CARE.—Behavioral health services
21 for Indians 56 years of age and older, including—

22 “(A) early intervention, treatment, and
23 aftercare;

1 “(B) mental health and substance abuse
2 services (emotional, alcohol, drug, inhalant, and
3 tobacco), including sex specific services;

4 “(C) identification and treatment of co-oc-
5 curring disorders (dual diagnosis) and comor-
6 bidity;

7 “(D) promotion of healthy approaches to
8 managing conditions related to aging;

9 “(E) sex specific treatment for sexual as-
10 sault, domestic violence, neglect, physical and
11 mental abuse and exploitation; and

12 “(F) identification and treatment of de-
13 mentias regardless of cause.

14 “(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

15 “(1) ESTABLISHMENT.—The governing body of
16 any Indian tribe, tribal organization, or urban In-
17 dian organization may adopt a resolution for the es-
18 tablishment of a community behavioral health plan
19 providing for the identification and coordination of
20 available resources and programs to identify, pre-
21 vent, or treat substance abuse, mental illness, or
22 dysfunctional and self-destructive behavior, including
23 child abuse and family violence, among its members
24 or its service population. This plan should include

1 behavioral health services, social services, intensive
2 outpatient services, and continuing aftercare.

3 “(2) TECHNICAL ASSISTANCE.—At the request
4 of an Indian tribe, tribal organization, or urban In-
5 dian organization, the Bureau of Indian Affairs and
6 the Service shall cooperate with and provide tech-
7 nical assistance to the Indian tribe, tribal organiza-
8 tion, or urban Indian organization in the develop-
9 ment and implementation of such plan.

10 “(3) FUNDING.—The Secretary, acting through
11 the Service, Indian tribes, and tribal organizations,
12 may make funding available to Indian tribes and
13 tribal organizations which adopt a resolution pursu-
14 ant to paragraph (1) to obtain technical assistance
15 for the development of a community behavioral
16 health plan and to provide administrative support in
17 the implementation of such plan.

18 “(e) COORDINATION FOR AVAILABILITY OF SERV-
19 ICES.—The Secretary, acting through the Service, shall
20 coordinate behavioral health planning, to the extent fea-
21 sible, with other Federal agencies and with State agencies,
22 to encourage comprehensive behavioral health services for
23 Indians regardless of their place of residence.

24 “(f) MENTAL HEALTH CARE NEED ASSESSMENT.—
25 Not later than 1 year after the date of enactment of the

1 Indian Healthcare Improvement Act of 2017, the Sec-
2 retary, acting through the Service, shall make an assess-
3 ment of the need for inpatient mental health care among
4 Indians and the availability and cost of inpatient mental
5 health facilities which can meet such need. In making such
6 assessment, the Secretary shall consider the possible con-
7 version of existing, underused Service hospital beds into
8 psychiatric units to meet such need.

9 **“SEC. 703. MEMORANDA OF AGREEMENT WITH THE DE-**
10 **PARTMENT OF INTERIOR.**

11 “(a) CONTENTS.—Not later than 1 year after the
12 date of enactment of the Indian Healthcare Improvement
13 Act of 2017, the Secretary, acting through the Service,
14 and the Secretary of the Interior shall develop and enter
15 into a memoranda of agreement, or review and update any
16 existing memoranda of agreement, as required by section
17 4205 of the Indian Alcohol and Substance Abuse Preven-
18 tion and Treatment Act of 1986 (25 U.S.C. 2411) under
19 which the Secretaries address the following:

20 “(1) The scope and nature of mental illness and
21 dysfunctional and self-destructive behavior, including
22 child abuse and family violence, among Indians.

23 “(2) The existing Federal, tribal, State, local,
24 and private services, resources, and programs avail-

1 able to provide behavioral health services for Indi-
2 ans.

3 “(3) The unmet need for additional services, re-
4 sources, and programs necessary to meet the needs
5 identified pursuant to paragraph (1).

6 “(4)(A) The right of Indians, as citizens of the
7 United States and of the States in which they re-
8 side, to have access to behavioral health services to
9 which all citizens have access.

10 “(B) The right of Indians to participate in, and
11 receive the benefit of, such services.

12 “(C) The actions necessary to protect the exer-
13 cise of such right.

14 “(5) The responsibilities of the Bureau of In-
15 dian Affairs and the Service, including mental illness
16 identification, prevention, education, referral, and
17 treatment services (including services through multi-
18 disciplinary resource teams), at the central, area,
19 and agency and Service unit, Service area, and head-
20 quarters levels to address the problems identified in
21 paragraph (1).

22 “(6) A strategy for the comprehensive coordina-
23 tion of the behavioral health services provided by the
24 Bureau of Indian Affairs and the Service to meet

1 the problems identified pursuant to paragraph (1),
2 including—

3 “(A) the coordination of alcohol and sub-
4 stance abuse programs of the Service, the Bu-
5 reau of Indian Affairs, and Indian tribes and
6 tribal organizations (developed under the Indian
7 Alcohol and Substance Abuse Prevention and
8 Treatment Act of 1986 (25 U.S.C. 2401 et
9 seq.)) with behavioral health initiatives pursu-
10 ant to this Act, particularly with respect to the
11 referral and treatment of dually diagnosed indi-
12 viduals requiring behavioral health and sub-
13 stance abuse treatment; and

14 “(B) ensuring that the Bureau of Indian
15 Affairs and Service programs and services (in-
16 cluding multidisciplinary resource teams) ad-
17 dressing child abuse and family violence are co-
18 ordinated with such non-Federal programs and
19 services.

20 “(7) Directing appropriate officials of the Bu-
21 reau of Indian Affairs and the Service, particularly
22 at the agency and Service unit levels, to cooperate
23 fully with tribal requests made pursuant to commu-
24 nity behavioral health plans adopted under section
25 702(c) and section 4206 of the Indian Alcohol and

1 Substance Abuse Prevention and Treatment Act of
2 1986 (25 U.S.C. 2412).

3 “(8) Providing for an annual review of such
4 agreement by the Secretaries which shall be provided
5 to Congress and Indian tribes and tribal organiza-
6 tions.

7 “(b) SPECIFIC PROVISIONS REQUIRED.—The memo-
8 randa of agreement updated or entered into pursuant to
9 subsection (a) shall include specific provisions pursuant to
10 which the Service shall assume responsibility for—

11 “(1) the determination of the scope of the prob-
12 lem of alcohol and substance abuse among Indians,
13 including the number of Indians within the jurisdic-
14 tion of the Service who are directly or indirectly af-
15 fected by alcohol and substance abuse and the finan-
16 cial and human cost;

17 “(2) an assessment of the existing and needed
18 resources necessary for the prevention of alcohol and
19 substance abuse and the treatment of Indians af-
20 fected by alcohol and substance abuse; and

21 “(3) an estimate of the funding necessary to
22 adequately support a program of prevention of alco-
23 hol and substance abuse and treatment of Indians
24 affected by alcohol and substance abuse.

1 “(c) PUBLICATION.—Each memorandum of agree-
2 ment entered into or renewed (and amendments or modi-
3 fications thereto) under subsection (a) shall be published
4 in the Federal Register. At the same time as publication
5 in the Federal Register, the Secretary shall provide a copy
6 of such memoranda, amendment, or modification to each
7 Indian tribe, tribal organization, and urban Indian organi-
8 zation.

9 **“SEC. 704. COMPREHENSIVE BEHAVIORAL HEALTH PRE-**
10 **VENTION AND TREATMENT PROGRAM.**

11 “(a) ESTABLISHMENT.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Service, shall provide a program of com-
14 prehensive behavioral health, prevention, treatment,
15 and aftercare, which may include, if feasible and ap-
16 propriate, systems of care, and shall include—

17 “(A) prevention, through educational inter-
18 vention, in Indian communities;

19 “(B) acute detoxification, psychiatric hos-
20 pitalization, residential, and intensive outpatient
21 treatment;

22 “(C) community-based rehabilitation and
23 aftercare;

24 “(D) community education and involve-
25 ment, including extensive training of health

1 care, educational, and community-based per-
2 sonnel;

3 “(E) specialized residential treatment pro-
4 grams for high-risk populations, including preg-
5 nant and postpartum women and their children;
6 and

7 “(F) diagnostic services.

8 “(2) TARGET POPULATIONS.—The target popu-
9 lation of such programs shall be members of Indian
10 tribes. Efforts to train and educate key members of
11 the Indian community shall also target employees of
12 health, education, judicial, law enforcement, legal,
13 and social service programs.

14 “(b) CONTRACT HEALTH SERVICES.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Service, may enter into contracts with
17 public or private providers of behavioral health treat-
18 ment services for the purpose of carrying out the
19 program required under subsection (a).

20 “(2) PROVISION OF ASSISTANCE.—In carrying
21 out this subsection, the Secretary shall provide as-
22 sistance to Indian tribes and tribal organizations to
23 develop criteria for the certification of behavioral
24 health service providers and accreditation of service

1 facilities which meet minimum standards for such
2 services and facilities.

3 **“SEC. 705. MENTAL HEALTH TECHNICIAN PROGRAM.**

4 “(a) IN GENERAL.—Pursuant to the Act of Novem-
5 ber 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Sny-
6 der Act’), the Secretary shall establish and maintain a
7 mental health technician program within the Service
8 which—

9 “(1) provides for the training of Indians as
10 mental health technicians; and

11 “(2) employs such technicians in the provision
12 of community-based mental health care that includes
13 identification, prevention, education, referral, and
14 treatment services.

15 “(b) PARAPROFESSIONAL TRAINING.—In carrying
16 out subsection (a), the Secretary, acting through the Serv-
17 ice, shall provide high-standard paraprofessional training
18 in mental health care necessary to provide quality care to
19 the Indian communities to be served. Such training shall
20 be based upon a curriculum developed or approved by the
21 Secretary which combines education in the theory of men-
22 tal health care with supervised practical experience in the
23 provision of such care.

24 “(c) SUPERVISION AND EVALUATION OF TECHNI-
25 CIANS.—The Secretary, acting through the Service, shall

1 supervise and evaluate the mental health technicians in
2 the training program.

3 “(d) TRADITIONAL HEALTH CARE PRACTICES.—The
4 Secretary, acting through the Service, shall ensure that
5 the program established pursuant to this section involves
6 the use and promotion of the traditional health care prac-
7 tices of the Indian tribes to be served.

8 **“SEC. 706. LICENSING REQUIREMENT FOR MENTAL**
9 **HEALTH CARE WORKERS.**

10 “(a) IN GENERAL.—Subject to section 221, and ex-
11 cept as provided in subsection (b), any individual employed
12 as a psychologist, social worker, or marriage and family
13 therapist for the purpose of providing mental health care
14 services to Indians in a clinical setting under this Act is
15 required to be licensed as a psychologist, social worker,
16 or marriage and family therapist, respectively.

17 “(b) TRAINEES.—An individual may be employed as
18 a trainee in psychology, social work, or marriage and fam-
19 ily therapy to provide mental health care services de-
20 scribed in subsection (a) if such individual—

21 “(1) works under the direct supervision of a li-
22 censed psychologist, social worker, or marriage and
23 family therapist, respectively;

24 “(2) is enrolled in or has completed at least 2
25 years of course work at a post-secondary, accredited

1 education program for psychology, social work, mar-
2 riage and family therapy, or counseling; and

3 “(3) meets such other training, supervision, and
4 quality review requirements as the Secretary may es-
5 tablish.

6 **“SEC. 707. INDIAN WOMEN TREATMENT PROGRAMS.**

7 “(a) GRANTS.—The Secretary, consistent with sec-
8 tion 702, may make grants to Indian tribes, tribal organi-
9 zations, and urban Indian organizations to develop and
10 implement a comprehensive behavioral health program of
11 prevention, intervention, treatment, and relapse preven-
12 tion services that specifically addresses the cultural, his-
13 torical, social, and child care needs of Indian women, re-
14 gardless of age.

15 “(b) USE OF GRANT FUNDS.—A grant made pursu-
16 ant to this section may be used—

17 “(1) to develop and provide community train-
18 ing, education, and prevention programs for Indian
19 women relating to behavioral health issues, including
20 fetal alcohol spectrum disorders;

21 “(2) to identify and provide psychological serv-
22 ices, counseling, advocacy, support, and relapse pre-
23 vention to Indian women and their families; and

24 “(3) to develop prevention and intervention
25 models for Indian women which incorporate tradi-

1 tional health care practices, cultural values, and
2 community and family involvement.

3 “(c) CRITERIA.—The Secretary, in consultation with
4 Indian tribes and tribal organizations, shall establish cri-
5 teria for the review and approval of applications and pro-
6 posals for funding under this section.

7 “(d) ALLOCATION OF FUNDS FOR URBAN INDIAN
8 ORGANIZATIONS.—20 percent of the funds appropriated
9 pursuant to this section shall be used to make grants to
10 urban Indian organizations.

11 **“SEC. 708. INDIAN YOUTH PROGRAM.**

12 “(a) DETOXIFICATION AND REHABILITATION.—The
13 Secretary, acting through the Service, consistent with sec-
14 tion 702, shall develop and implement a program for acute
15 detoxification and treatment for Indian youths, including
16 behavioral health services. The program shall include re-
17 gional treatment centers designed to include detoxification
18 and rehabilitation for both sexes on a referral basis and
19 programs developed and implemented by Indian tribes or
20 tribal organizations at the local level under the Indian
21 Self-Determination and Education Assistance Act (25
22 U.S.C. 450 et seq.). Regional centers shall be integrated
23 with the intake and rehabilitation programs based in the
24 referring Indian community.

1 “(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT
2 CENTERS OR FACILITIES.—

3 “(1) ESTABLISHMENT.—

4 “(A) IN GENERAL.—The Secretary, acting
5 through the Service, shall construct, renovate,
6 or, as necessary, purchase, and appropriately
7 staff and operate, at least 1 youth regional
8 treatment center or treatment network in each
9 area under the jurisdiction of an area office.

10 “(B) AREA OFFICE IN CALIFORNIA.—For
11 the purposes of this subsection, the area office
12 in California shall be considered to be 2 area
13 offices, 1 office whose jurisdiction shall be con-
14 sidered to encompass the northern area of the
15 State of California, and 1 office whose jurisdic-
16 tion shall be considered to encompass the re-
17 mainder of the State of California for the pur-
18 pose of implementing California treatment net-
19 works.

20 “(2) FUNDING.—For the purpose of staffing
21 and operating such centers or facilities, funding
22 shall be pursuant to the Act of November 2, 1921
23 (25 U.S.C. 13).

24 “(3) LOCATION.—A youth treatment center
25 constructed or purchased under this subsection shall

1 be constructed or purchased at a location within the
2 area described in paragraph (1) agreed upon (by ap-
3 propriate tribal resolution) by a majority of the In-
4 dian tribes to be served by such center.

5 “(4) SPECIFIC PROVISION OF FUNDS.—

6 “(A) IN GENERAL.—Notwithstanding any
7 other provision of this title, the Secretary may,
8 from amounts authorized to be appropriated for
9 the purposes of carrying out this section, make
10 funds available to—

11 “(i) the Tanana Chiefs Conference,
12 Incorporated, for the purpose of leasing,
13 constructing, renovating, operating, and
14 maintaining a residential youth treatment
15 facility in Fairbanks, Alaska; and

16 “(ii) the Southeast Alaska Regional
17 Health Corporation to staff and operate a
18 residential youth treatment facility without
19 regard to the proviso set forth in section
20 4(l) of the Indian Self-Determination and
21 Education Assistance Act (25 U.S.C.
22 450b(l)).

23 “(B) PROVISION OF SERVICES TO ELIGI-
24 BLE YOUTHS.—Until additional residential
25 youth treatment facilities are established in

1 Alaska pursuant to this section, the facilities
2 specified in subparagraph (A) shall make every
3 effort to provide services to all eligible Indian
4 youths residing in Alaska.

5 “(c) INTERMEDIATE ADOLESCENT BEHAVIORAL
6 HEALTH SERVICES.—

7 “(1) IN GENERAL.—The Secretary, acting
8 through the Service, may provide intermediate be-
9 havioral health services, which may , if feasible and
10 appropriate, incorporate systems of care, to Indian
11 children and adolescents, including—

12 “(A) pretreatment assistance;

13 “(B) inpatient, outpatient, and aftercare
14 services;

15 “(C) emergency care;

16 “(D) suicide prevention and crisis interven-
17 tion; and

18 “(E) prevention and treatment of mental
19 illness and dysfunctional and self-destructive
20 behavior, including child abuse and family vio-
21 lence.

22 “(2) USE OF FUNDS.—Funds provided under
23 this subsection may be used—

1 “(A) to construct or renovate an existing
2 health facility to provide intermediate behav-
3 ioral health services;

4 “(B) to hire behavioral health profes-
5 sionals;

6 “(C) to staff, operate, and maintain an in-
7 termediate mental health facility, group home,
8 sober housing, transitional housing or similar
9 facilities, or youth shelter where intermediate
10 behavioral health services are being provided;

11 “(D) to make renovations and hire appro-
12 priate staff to convert existing hospital beds
13 into adolescent psychiatric units; and

14 “(E) for intensive home- and community-
15 based services.

16 “(3) CRITERIA.—The Secretary, acting through
17 the Service, shall, in consultation with Indian tribes
18 and tribal organizations, establish criteria for the re-
19 view and approval of applications or proposals for
20 funding made available pursuant to this subsection.

21 “(d) FEDERALLY OWNED STRUCTURES.—

22 “(1) IN GENERAL.—The Secretary, in consulta-
23 tion with Indian tribes and tribal organizations,
24 shall—

1 “(A) identify and use, where appropriate,
2 federally owned structures suitable for local res-
3 idential or regional behavioral health treatment
4 for Indian youths; and

5 “(B) establish guidelines for determining
6 the suitability of any such federally owned
7 structure to be used for local residential or re-
8 gional behavioral health treatment for Indian
9 youths.

10 “(2) TERMS AND CONDITIONS FOR USE OF
11 STRUCTURE.—Any structure described in paragraph
12 (1) may be used under such terms and conditions as
13 may be agreed upon by the Secretary and the agency
14 having responsibility for the structure and any In-
15 dian tribe or tribal organization operating the pro-
16 gram.

17 “(e) REHABILITATION AND AFTERCARE SERVICES.—

18 “(1) IN GENERAL.—The Secretary, Indian
19 tribes, or tribal organizations, in cooperation with
20 the Secretary of the Interior, shall develop and im-
21 plement within each Service unit, community-based
22 rehabilitation and follow-up services for Indian
23 youths who are having significant behavioral health
24 problems, and require long-term treatment, commu-
25 nity reintegration, and monitoring to support the In-

1 dian youths after their return to their home commu-
2 nity.

3 “(2) ADMINISTRATION.—Services under para-
4 graph (1) shall be provided by trained staff within
5 the community who can assist the Indian youths in
6 their continuing development of self-image, positive
7 problem-solving skills, and nonalcohol or substance
8 abusing behaviors. Such staff may include alcohol
9 and substance abuse counselors, mental health pro-
10 fessionals, and other health professionals and para-
11 professionals, including community health represent-
12 atives.

13 “(f) INCLUSION OF FAMILY IN YOUTH TREATMENT
14 PROGRAM.—In providing the treatment and other services
15 to Indian youths authorized by this section, the Secretary,
16 acting through the Service, shall provide for the inclusion
17 of family members of such youths in the treatment pro-
18 grams or other services as may be appropriate. Not less
19 than 10 percent of the funds appropriated for the pur-
20 poses of carrying out subsection (e) shall be used for out-
21 patient care of adult family members related to the treat-
22 ment of an Indian youth under that subsection.

23 “(g) MULTIDRUG ABUSE PROGRAM.—The Secretary,
24 acting through the Service, shall provide, consistent with
25 section 702, programs and services to prevent and treat

1 the abuse of multiple forms of substances, including alco-
2 hol, drugs, inhalants, and tobacco, among Indian youths
3 residing in Indian communities, on or near reservations,
4 and in urban areas and provide appropriate mental health
5 services to address the incidence of mental illness among
6 such youths.

7 “(h) INDIAN YOUTH MENTAL HEALTH.—The Sec-
8 retary, acting through the Service, shall collect data for
9 the report under section 801 with respect to—

10 “(1) the number of Indian youth who are being
11 provided mental health services through the Service
12 and tribal health programs;

13 “(2) a description of, and costs associated with,
14 the mental health services provided for Indian youth
15 through the Service and tribal health programs;

16 “(3) the number of youth referred to the Serv-
17 ice or tribal health programs for mental health serv-
18 ices;

19 “(4) the number of Indian youth provided resi-
20 dential treatment for mental health and behavioral
21 problems through the Service and tribal health pro-
22 grams, reported separately for on- and off-reserva-
23 tion facilities; and

24 “(5) the costs of the services described in para-
25 graph (4).

1 **“SEC. 709. INPATIENT AND COMMUNITY-BASED MENTAL**
2 **HEALTH FACILITIES DESIGN, CONSTRUC-**
3 **TION, AND STAFFING.**

4 “Not later than 1 year after the date of enactment
5 of the Indian Healthcare Improvement Act of 2017, the
6 Secretary, acting through the Service, may provide, in
7 each area of the Service, not less than 1 inpatient mental
8 health care facility, or the equivalent, for Indians with be-
9 havioral health problems. For the purposes of this sub-
10 section, California shall be considered to be 2 area offices,
11 1 office whose location shall be considered to encompass
12 the northern area of the State of California and 1 office
13 whose jurisdiction shall be considered to encompass the
14 remainder of the State of California. The Secretary shall
15 consider the possible conversion of existing, underused
16 Service hospital beds into psychiatric units to meet such
17 need.

18 **“SEC. 710. TRAINING AND COMMUNITY EDUCATION.**

19 “(a) PROGRAM.—The Secretary, in cooperation with
20 the Secretary of the Interior, shall develop and implement
21 or assist Indian tribes and tribal organizations to develop
22 and implement, within each Service unit or tribal program,
23 a program of community education and involvement which
24 shall be designed to provide concise and timely information
25 to the community leadership of each tribal community.
26 Such program shall include education about behavioral

1 health issues to political leaders, tribal judges, law en-
2 forcement personnel, members of tribal health and edu-
3 cation boards, health care providers including traditional
4 practitioners, and other critical members of each tribal
5 community. Such program may also include community-
6 based training to develop local capacity and tribal commu-
7 nity provider training for prevention, intervention, treat-
8 ment, and aftercare.

9 “(b) INSTRUCTION.—The Secretary, acting through
10 the Service, shall provide instruction in the area of behav-
11 ioral health issues, including instruction in crisis interven-
12 tion and family relations in the context of alcohol and sub-
13 stance abuse, child sexual abuse, youth alcohol and sub-
14 stance abuse, and the causes and effects of fetal alcohol
15 spectrum disorders to appropriate employees of the Bu-
16 reau of Indian Affairs and the Service, and to personnel
17 in schools or programs operated under any contract with
18 the Bureau of Indian Affairs or the Service, including su-
19 pervisors of emergency shelters and halfway houses de-
20 scribed in section 4213 of the Indian Alcohol and Sub-
21 stance Abuse Prevention and Treatment Act of 1986 (25
22 U.S.C. 2433).

23 “(c) TRAINING MODELS.—In carrying out the edu-
24 cation and training programs required by this section, the
25 Secretary, in consultation with Indian tribes, tribal organi-

1 zations, Indian behavioral health experts, and Indian alco-
2 hol and substance abuse prevention experts, shall develop
3 and provide community-based training models. Such mod-
4 els shall address—

5 “(1) the elevated risk of alcohol abuse and
6 other behavioral health problems faced by children of
7 alcoholics;

8 “(2) the cultural, spiritual, and
9 multigenerational aspects of behavioral health prob-
10 lem prevention and recovery; and

11 “(3) community-based and multidisciplinary
12 strategies for preventing and treating behavioral
13 health problems.

14 **“SEC. 711. BEHAVIORAL HEALTH PROGRAM.**

15 “(a) INNOVATIVE PROGRAMS.—The Secretary, acting
16 through the Service, consistent with section 702, may
17 plan, develop, implement, and carry out programs to de-
18 liver innovative community-based behavioral health serv-
19 ices to Indians.

20 “(b) AWARDS; CRITERIA.—The Secretary may award
21 a grant for a project under subsection (a) to an Indian
22 tribe or tribal organization and may consider the following
23 criteria:

24 “(1) The project will address significant unmet
25 behavioral health needs among Indians.

1 “(2) The project will serve a significant number
2 of Indians.

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

5 “(4) The Indian tribe or tribal organization has
6 the administrative and financial capability to admin-
7 ister the project.

8 “(5) The project may deliver services in a man-
9 ner consistent with traditional health care practices.

10 “(6) The project is coordinated with, and avoids
11 duplication of, existing services.

12 “(c) **EQUITABLE TREATMENT.**—For purposes of this
13 subsection, the Secretary shall, in evaluating project appli-
14 cations or proposals, use the same criteria that the Sec-
15 retary uses in evaluating any other application or proposal
16 for such funding.

17 **“SEC. 712. FETAL ALCOHOL SPECTRUM DISORDERS PRO-**
18 **GRAMS.**

19 “(a) **PROGRAMS.**—

20 “(1) **ESTABLISHMENT.**—The Secretary, con-
21 sistent with section 702, acting through the Service,
22 Indian Tribes, and Tribal Organizations, is author-
23 ized to establish and operate fetal alcohol spectrum
24 disorders programs as provided in this section for

1 the purposes of meeting the health status objectives
2 specified in section 3.

3 “(2) USE OF FUNDS.—

4 “(A) IN GENERAL.—Funding provided
5 pursuant to this section shall be used for the
6 following:

7 “(i) To develop and provide for Indi-
8 ans community and in-school training, edu-
9 cation, and prevention programs relating
10 to fetal alcohol spectrum disorders.

11 “(ii) To identify and provide behav-
12 ioral health treatment to high-risk Indian
13 women and high-risk women pregnant with
14 an Indian’s child.

15 “(iii) To identify and provide appro-
16 priate psychological services, educational
17 and vocational support, counseling, advo-
18 cacy, and information to fetal alcohol spec-
19 trum disorders-affected Indians and their
20 families or caretakers.

21 “(iv) To develop and implement coun-
22 seling and support programs in schools for
23 fetal alcohol spectrum disorders-affected
24 Indian children.

1 “(v) To develop prevention and inter-
2 vention models which incorporate practi-
3 tioners of traditional health care practices,
4 cultural values, and community involve-
5 ment.

6 “(vi) To develop, print, and dissemi-
7 nate education and prevention materials on
8 fetal alcohol spectrum disorders.

9 “(vii) To develop and implement, in
10 consultation with Indian Tribes and Tribal
11 Organizations, and in conference with
12 urban Indian Organizations, culturally sen-
13 sitive assessment and diagnostic tools in-
14 cluding dysmorphology clinics and multi-
15 disciplinary fetal alcohol spectrum dis-
16 orders clinics for use in Indian commu-
17 nities and urban Centers.

18 “(viii) To develop and provide training
19 on fetal alcohol spectrum disorders to pro-
20 fessionals providing services to Indians, in-
21 cluding medical and allied health practi-
22 tioners, social service providers, educators,
23 and law enforcement, court officials and
24 corrections personnel in the juvenile and
25 criminal justice systems.

1 “(B) ADDITIONAL USES.—In addition to
2 any purpose under subparagraph (A), funding
3 provided pursuant to this section may be used
4 for 1 or more of the following:

5 “(i) Early childhood intervention
6 projects from birth on to mitigate the ef-
7 fects of fetal alcohol spectrum disorders
8 among Indians.

9 “(ii) Community-based support serv-
10 ices for Indians and women pregnant with
11 Indian children.

12 “(iii) Community-based housing for
13 adult Indians with fetal alcohol spectrum
14 disorders.

15 “(3) CRITERIA FOR APPLICATIONS.—The Sec-
16 retary shall establish criteria for the review and ap-
17 proval of applications for funding under this section.

18 “(b) SERVICES.—The Secretary, acting through the
19 Service, Indian Tribes, and Tribal Organizations, shall—

20 “(1) develop and provide services for the pre-
21 vention, intervention, treatment, and aftercare for
22 those affected by fetal alcohol spectrum disorders in
23 Indian communities; and

24 “(2) provide supportive services, including serv-
25 ices to meet the special educational, vocational,

1 school-to-work transition, and independent living
2 needs of adolescent and adult Indians with fetal al-
3 cohol spectrum disorders.

4 “(c) APPLIED RESEARCH PROJECTS.—The Sec-
5 retary, acting through the Substance Abuse and Mental
6 Health Services Administration, shall make grants to In-
7 dian Tribes, Tribal Organizations, and urban Indian Or-
8 ganizations for applied research projects which propose to
9 elevate the understanding of methods to prevent, inter-
10 vene, treat, or provide rehabilitation and behavioral health
11 aftercare for Indians and urban Indians affected by fetal
12 alcohol spectrum disorders.

13 “(d) FUNDING FOR URBAN INDIAN ORGANIZA-
14 TIONS.—Ten percent of the funds appropriated pursuant
15 to this section shall be used to make grants to urban In-
16 dian Organizations funded under title V.

17 **“SEC. 713. CHILD SEXUAL ABUSE PREVENTION AND TREAT-**
18 **MENT PROGRAMS.**

19 “(a) ESTABLISHMENT.—The Secretary, acting
20 through the Service, shall establish, consistent with section
21 702, in every Service area, programs involving treatment
22 for—

23 “(1) victims of sexual abuse who are Indian
24 children or children in an Indian household; and

1 “(2) other members of the household or family
2 of the victims described in paragraph (1).

3 “(b) USE OF FUNDS.—Funding provided pursuant to
4 this section shall be used for the following:

5 “(1) To develop and provide community edu-
6 cation and prevention programs related to sexual
7 abuse of Indian children or children in an Indian
8 household.

9 “(2) To identify and provide behavioral health
10 treatment to victims of sexual abuse who are Indian
11 children or children in an Indian household, and to
12 their family members who are affected by sexual
13 abuse.

14 “(3) To develop prevention and intervention
15 models which incorporate traditional health care
16 practices, cultural values, and community involve-
17 ment.

18 “(4) To develop and implement culturally sen-
19 sitive assessment and diagnostic tools for use in In-
20 dian communities and urban centers.

21 “(c) COORDINATION.—The programs established
22 under subsection (a) shall be carried out in coordination
23 with programs and services authorized under the Indian
24 Child Protection and Family Violence Prevention Act (25
25 U.S.C. 3201 et seq.).

1 **“SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION**
2 **AND TREATMENT.**

3 “(a) IN GENERAL.—The Secretary, in accordance
4 with section 702, is authorized to establish in each Service
5 area programs involving the prevention and treatment
6 of—

7 “(1) Indian victims of domestic violence or sex-
8 ual abuse; and

9 “(2) other members of the household or family
10 of the victims described in paragraph (1).

11 “(b) USE OF FUNDS.—Funds made available to carry
12 out this section shall be used—

13 “(1) to develop and implement prevention pro-
14 grams and community education programs relating
15 to domestic violence and sexual abuse;

16 “(2) to provide behavioral health services, in-
17 cluding victim support services, and medical treat-
18 ment (including examinations performed by sexual
19 assault nurse examiners) to Indian victims of domes-
20 tic violence or sexual abuse;

21 “(3) to purchase rape kits; and

22 “(4) to develop prevention and intervention
23 models, which may incorporate traditional health
24 care practices.

25 “(c) TRAINING AND CERTIFICATION.—

1 “(1) IN GENERAL.—Not later than 1 year after
2 the date of enactment of the Indian Healthcare Im-
3 provement Act of 2017, the Secretary shall establish
4 appropriate protocols, policies, procedures, standards
5 of practice, and, if not available elsewhere, training
6 curricula and training and certification requirements
7 for services for victims of domestic violence and sex-
8 ual abuse.

9 “(2) REPORT.—Not later than 18 months after
10 the date of enactment of the Indian Healthcare Im-
11 provement Act of 2017, the Secretary shall submit
12 to the Committee on Indian Affairs of the Senate
13 and the Committee on Natural Resources of the
14 House of Representatives a report that describes the
15 means and extent to which the Secretary has carried
16 out paragraph (1).

17 “(d) COORDINATION.—

18 “(1) IN GENERAL.—The Secretary, in coordina-
19 tion with the Attorney General, Federal and tribal
20 law enforcement agencies, Indian health programs,
21 and domestic violence or sexual assault victim orga-
22 nizations, shall develop appropriate victim services
23 and victim advocate training programs—

24 “(A) to improve domestic violence or sex-
25 ual abuse responses;

1 “(B) to improve forensic examinations and
2 collection;

3 “(C) to identify problems or obstacles in
4 the prosecution of domestic violence or sexual
5 abuse; and

6 “(D) to meet other needs or carry out
7 other activities required to prevent, treat, and
8 improve prosecutions of domestic violence and
9 sexual abuse.

10 “(2) REPORT.—Not later than 2 years after the
11 date of enactment of the Indian Healthcare Im-
12 provement Act of 2017, the Secretary shall submit
13 to the Committee on Indian Affairs of the Senate
14 and the Committee on Natural Resources of the
15 House of Representatives a report that describes,
16 with respect to the matters described in paragraph
17 (1), the improvements made and needed, problems
18 or obstacles identified, and costs necessary to ad-
19 dress the problems or obstacles, and any other rec-
20 ommendations that the Secretary determines to be
21 appropriate.

22 **“SEC. 715. BEHAVIORAL HEALTH RESEARCH.**

23 “(a) IN GENERAL.—The Secretary, in consultation
24 with appropriate Federal agencies, shall make grants to,
25 or enter into contracts with, Indian tribes, tribal organiza-

1 tions, and urban Indian organizations or enter into con-
2 tracts with, or make grants to appropriate institutions for,
3 the conduct of research on the incidence and prevalence
4 of behavioral health problems among Indians served by the
5 Service, Indian tribes, or tribal organizations and among
6 Indians in urban areas. Research priorities under this sec-
7 tion shall include—

8 “(1) the multifactorial causes of Indian youth
9 suicide, including—

10 “(A) protective and risk factors and sci-
11 entific data that identifies those factors; and

12 “(B) the effects of loss of cultural identity
13 and the development of scientific data on those
14 effects;

15 “(2) the interrelationship and interdependence
16 of behavioral health problems with alcoholism and
17 other substance abuse, suicide, homicides, other in-
18 juries, and the incidence of family violence; and

19 “(3) the development of models of prevention
20 techniques.

21 “(b) EMPHASIS.—The effect of the interrelationships
22 and interdependencies referred to in subsection (a)(2) on
23 children, and the development of prevention techniques
24 under subsection (a)(3) applicable to children, shall be em-
25 phasized.

1 **“Subtitle B—Indian Youth Suicide**
2 **Prevention**

3 **“SEC. 721. FINDINGS AND PURPOSE.**

4 “(a) FINDINGS.—Congress finds that—

5 “(1)(A) the rate of suicide of American Indians
6 and Alaska Natives is 1.9 times higher than the na-
7 tional average rate; and

8 “(B) the rate of suicide of Indian and Alaska
9 Native youth aged 15 through 24 is—

10 “(i) 3.5 times the national average rate;
11 and

12 “(ii) the highest rate of any population
13 group in the United States;

14 “(2) many risk behaviors and contributing fac-
15 tors for suicide are more prevalent in Indian country
16 than in other areas, including—

17 “(A) history of previous suicide attempts;

18 “(B) family history of suicide;

19 “(C) history of depression or other mental
20 illness;

21 “(D) alcohol or drug abuse;

22 “(E) health disparities;

23 “(F) stressful life events and losses;

24 “(G) easy access to lethal methods;

1 “(H) exposure to the suicidal behavior of
2 others;

3 “(I) isolation; and

4 “(J) incarceration;

5 “(3) according to national data for 2005, sui-
6 cide was the second-leading cause of death for Indi-
7 ans and Alaska Natives of both sexes aged 10
8 through 34;

9 “(4)(A) the suicide rates of Indian and Alaska
10 Native males aged 15 through 24 are—

11 “(i) as compared to suicide rates of males
12 of any other racial group, up to 4 times greater;
13 and

14 “(ii) as compared to suicide rates of fe-
15 males of any other racial group, up to 11 times
16 greater; and

17 “(B) data demonstrates that, over their life-
18 times, females attempt suicide 2 to 3 times more
19 often than males;

20 “(5)(A) Indian tribes, especially Indian tribes
21 located in the Great Plains, have experienced epi-
22 demic levels of suicide, up to 10 times the national
23 average; and

24 “(B) suicide clustering in Indian country affects
25 entire tribal communities;

1 “(6) death rates for Indians and Alaska Natives
2 are statistically underestimated because many areas
3 of Indian country lack the proper resources to iden-
4 tify and monitor the presence of disease;

5 “(7)(A) the Indian Health Service experiences
6 health professional shortages, with physician vacancy
7 rates of approximately 17 percent, and nursing va-
8 cancy rates of approximately 18 percent, in 2007;

9 “(B) 90 percent of all teens who die by suicide
10 suffer from a diagnosable mental illness at time of
11 death;

12 “(C) more than $\frac{1}{2}$ of teens who die by suicide
13 have never been seen by a mental health provider;
14 and

15 “(D) $\frac{1}{3}$ of health needs in Indian country re-
16 late to mental health;

17 “(8) often, the lack of resources of Indian
18 tribes and the remote nature of Indian reservations
19 make it difficult to meet the requirements necessary
20 to access Federal assistance, including grants;

21 “(9) the Substance Abuse and Mental Health
22 Services Administration and the Service have estab-
23 lished specific initiatives to combat youth suicide in
24 Indian country and among Indians and Alaska Na-
25 tives throughout the United States, including the

1 National Suicide Prevention Initiative of the Service,
2 which has worked with Service, tribal, and urban In-
3 dian health programs since 2003;

4 “(10) the National Strategy for Suicide Preven-
5 tion was established in 2001 through a Department
6 of Health and Human Services collaboration
7 among—

8 “(A) the Substance Abuse and Mental
9 Health Services Administration;

10 “(B) the Service;

11 “(C) the Centers for Disease Control and
12 Prevention;

13 “(D) the National Institutes of Health;
14 and

15 “(E) the Health Resources and Services
16 Administration; and

17 “(11) the Service and other agencies of the De-
18 partment of Health and Human Services use infor-
19 mation technology and other programs to address
20 the suicide prevention and mental health needs of
21 Indians and Alaska Natives.

22 “(b) PURPOSES.—The purposes of this subtitle are—

23 “(1) to authorize the Secretary to carry out a
24 demonstration project to test the use of telemental

1 health services in suicide prevention, intervention,
2 and treatment of Indian youth, including through—

3 “(A) the use of psychotherapy, psychiatric
4 assessments, diagnostic interviews, therapies for
5 mental health conditions predisposing to sui-
6 cide, and alcohol and substance abuse treat-
7 ment;

8 “(B) the provision of clinical expertise to,
9 consultation services with, and medical advice
10 and training for frontline health care providers
11 working with Indian youth;

12 “(C) training and related support for com-
13 munity leaders, family members, and health
14 and education workers who work with Indian
15 youth;

16 “(D) the development of culturally relevant
17 educational materials on suicide; and

18 “(E) data collection and reporting;

19 “(2) to encourage Indian tribes, tribal organiza-
20 tions, and other mental health care providers serving
21 residents of Indian country to obtain the services of
22 predoctoral psychology and psychiatry interns; and

23 “(3) to enhance the provision of mental health
24 care services to Indian youth through existing grant

1 programs of the Substance Abuse and Mental
2 Health Services Administration.

3 **“SEC. 722. DEFINITIONS.**

4 “In this subtitle:

5 “(1) ADMINISTRATION.—The term ‘Administra-
6 tion’ means the Substance Abuse and Mental Health
7 Services Administration.

8 “(2) DEMONSTRATION PROJECT.—The term
9 ‘demonstration project’ means the Indian youth tele-
10 mental health demonstration project authorized
11 under section 723(a).

12 “(3) TELEMENTAL HEALTH.—The term ‘tele-
13 mental health’ means the use of electronic informa-
14 tion and telecommunications technologies to support
15 long-distance mental health care, patient and profes-
16 sional-related education, public health, and health
17 administration.

18 **“SEC. 723. INDIAN YOUTH TELEMENTAL HEALTH DEM-**
19 **ONSTRATION PROJECT.**

20 “(a) AUTHORIZATION.—

21 “(1) IN GENERAL.—The Secretary, acting
22 through the Service, is authorized to carry out a
23 demonstration project to award grants for the provi-
24 sion of telemental health services to Indian youth
25 who—

1 “(A) have expressed suicidal ideas;

2 “(B) have attempted suicide; or

3 “(C) have behavioral health conditions that
4 increase or could increase the risk of suicide.

5 “(2) ELIGIBILITY FOR GRANTS.—Grants under
6 paragraph (1) shall be awarded to Indian tribes and
7 tribal organizations that operate 1 or more facili-
8 ties—

9 “(A) located in an area with documented
10 disproportionately high rates of suicide;

11 “(B) reporting active clinical telehealth ca-
12 pabilities; or

13 “(C) offering school-based telemental
14 health services to Indian youth.

15 “(3) GRANT PERIOD.—The Secretary shall
16 award grants under this section for a period of up
17 to 4 years.

18 “(4) MAXIMUM NUMBER OF GRANTS.—Not
19 more than 5 grants shall be provided under para-
20 graph (1), with priority consideration given to In-
21 dian tribes and tribal organizations that—

22 “(A) serve a particular community or geo-
23 graphic area in which there is a demonstrated
24 need to address Indian youth suicide;

1 “(B) enter into collaborative partnerships
2 with Service or other tribal health programs or
3 facilities to provide services under this dem-
4 onstration project;

5 “(C) serve an isolated community or geo-
6 graphic area that has limited or no access to
7 behavioral health services; or

8 “(D) operate a detention facility at which
9 Indian youth are detained.

10 “(5) CONSULTATION WITH ADMINISTRATION.—

11 In developing and carrying out the demonstration
12 project under this subsection, the Secretary shall
13 consult with the Administration as the Federal agen-
14 cy focused on mental health issues, including suicide.

15 “(b) USE OF FUNDS.—

16 “(1) IN GENERAL.—An Indian tribe or tribal
17 organization shall use a grant received under sub-
18 section (a) for the following purposes:

19 “(A) To provide telemental health services
20 to Indian youth, including the provision of—

21 “(i) psychotherapy;

22 “(ii) psychiatric assessments and di-
23 agnostic interviews, therapies for mental
24 health conditions predisposing to suicide,
25 and treatment; and

1 “(iii) alcohol and substance abuse
2 treatment.

3 “(B) To provide clinician-interactive med-
4 ical advice, guidance and training, assistance in
5 diagnosis and interpretation, crisis counseling
6 and intervention, and related assistance to
7 Service or tribal clinicians and health services
8 providers working with youth being served
9 under the demonstration project.

10 “(C) To assist, educate, and train commu-
11 nity leaders, health education professionals and
12 paraprofessionals, tribal outreach workers, and
13 family members who work with the youth re-
14 ceiving telemental health services under the
15 demonstration project, including with identifica-
16 tion of suicidal tendencies, crisis intervention
17 and suicide prevention, emergency skill develop-
18 ment, and building and expanding networks
19 among those individuals and with State and
20 local health services providers.

21 “(D) To develop and distribute culturally
22 appropriate community educational materials
23 regarding—

24 “(i) suicide prevention;

25 “(ii) suicide education;

1 “(iii) suicide screening;

2 “(iv) suicide intervention; and

3 “(v) ways to mobilize communities
4 with respect to the identification of risk
5 factors for suicide.

6 “(E) To conduct data collection and re-
7 porting relating to Indian youth suicide preven-
8 tion efforts.

9 “(2) TRADITIONAL HEALTH CARE PRAC-
10 TICES.—In carrying out the purposes described in
11 paragraph (1), an Indian tribe or tribal organization
12 may use and promote the traditional health care
13 practices of the Indian tribes of the youth to be
14 served.

15 “(c) APPLICATIONS.—

16 “(1) IN GENERAL.—Subject to paragraph (2),
17 to be eligible to receive a grant under subsection (a),
18 an Indian tribe or tribal organization shall prepare
19 and submit to the Secretary an application, at such
20 time, in such manner, and containing such informa-
21 tion as the Secretary may require, including—

22 “(A) a description of the project that the
23 Indian tribe or tribal organization will carry out
24 using the funds provided under the grant;

1 “(B) a description of the manner in which
2 the project funded under the grant would—

3 “(i) meet the telemental health care
4 needs of the Indian youth population to be
5 served by the project; or

6 “(ii) improve the access of the Indian
7 youth population to be served to suicide
8 prevention and treatment services;

9 “(C) evidence of support for the project
10 from the local community to be served by the
11 project;

12 “(D) a description of how the families and
13 leadership of the communities or populations to
14 be served by the project would be involved in
15 the development and ongoing operations of the
16 project;

17 “(E) a plan to involve the tribal commu-
18 nity of the youth who are provided services by
19 the project in planning and evaluating the be-
20 havioral health care and suicide prevention ef-
21 forts provided, in order to ensure the integra-
22 tion of community, clinical, environmental, and
23 cultural components of the treatment; and

1 “(F) a plan for sustaining the project after
2 Federal assistance for the demonstration
3 project has terminated.

4 “(2) EFFICIENCY OF GRANT APPLICATION
5 PROCESS.—The Secretary shall carry out such meas-
6 ures as the Secretary determines to be necessary to
7 maximize the time and workload efficiency of the
8 process by which Indian tribes and tribal organiza-
9 tions apply for grants under paragraph (1).

10 “(d) COLLABORATION.—The Secretary, acting
11 through the Service, shall encourage Indian tribes and
12 tribal organizations receiving grants under this section to
13 collaborate to enable comparisons regarding best practices
14 across projects.

15 “(e) ANNUAL REPORT.—Each grant recipient shall
16 submit to the Secretary an annual report that—

17 “(1) describes the number of telemental health
18 services provided; and

19 “(2) includes any other information that the
20 Secretary may require.

21 “(f) REPORTS TO CONGRESS.—

22 “(1) INITIAL REPORT.—

23 “(A) IN GENERAL.—Not later than 2 years
24 after the date on which the first grant is award-
25 ed under this section, the Secretary shall sub-

1 mit to the Committee on Indian Affairs of the
2 Senate and the Committee on Natural Re-
3 sources and the Committee on Energy and
4 Commerce of the House of Representatives a
5 report that—

6 “(i) describes each project funded by
7 a grant under this section during the pre-
8 ceding 2-year period, including a descrip-
9 tion of the level of success achieved by the
10 project; and

11 “(ii) evaluates whether the demonstra-
12 tion project should be continued during the
13 period beginning on the date of termi-
14 nation of funding for the demonstration
15 project under subsection (g) and ending on
16 the date on which the final report is sub-
17 mitted under paragraph (2).

18 “(B) CONTINUATION OF DEMONSTRATION
19 PROJECT.—On a determination by the Sec-
20 retary under clause (ii) of subparagraph (A)
21 that the demonstration project should be con-
22 tinued, the Secretary may carry out the dem-
23 onstration project during the period described
24 in that clause using such sums otherwise made

1 available to the Secretary as the Secretary de-
2 termines to be appropriate.

3 “(2) FINAL REPORT.—Not later than 270 days
4 after the date of termination of funding for the dem-
5 onstration project under subsection (g), the Sec-
6 retary shall submit to the Committee on Indian Af-
7 fairs of the Senate and the Committee on Natural
8 Resources and the Committee on Energy and Com-
9 merce of the House of Representatives a final report
10 that—

11 “(A) describes the results of the projects
12 funded by grants awarded under this section,
13 including any data available that indicate the
14 number of attempted suicides;

15 “(B) evaluates the impact of the tele-
16 mental health services funded by the grants in
17 reducing the number of completed suicides
18 among Indian youth;

19 “(C) evaluates whether the demonstration
20 project should be—

21 “(i) expanded to provide more than 5
22 grants; and

23 “(ii) designated as a permanent pro-
24 gram; and

1 “(D) evaluates the benefits of expanding
2 the demonstration project to include urban In-
3 dian organizations.

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 \$1,500,000 for each of fiscal years 2017 through 2019.

7 **“SEC. 724. SUBSTANCE ABUSE AND MENTAL HEALTH SERV-**
8 **ICES ADMINISTRATION GRANTS.**

9 “(a) GRANT APPLICATIONS.—

10 “(1) EFFICIENCY OF GRANT APPLICATION
11 PROCESS.—The Secretary, acting through the Ad-
12 ministration, shall carry out such measures as the
13 Secretary determines to be necessary to maximize
14 the time and workload efficiency of the process by
15 which Indian tribes and tribal organizations apply
16 for grants under any program administered by the
17 Administration, including by providing methods
18 other than electronic methods of submitting applica-
19 tions for those grants, if necessary.

20 “(2) PRIORITY FOR CERTAIN GRANTS.—

21 “(A) IN GENERAL.—To fulfill the trust re-
22 sponsibility of the United States to Indian
23 tribes, in awarding relevant grants pursuant to
24 a program described in subparagraph (B), the
25 Secretary shall take into consideration the

1 needs of Indian tribes or tribal organizations,
2 as applicable, that serve populations with docu-
3 mented high suicide rates, regardless of whether
4 those Indian tribes or tribal organizations pos-
5 sess adequate personnel or infrastructure to ful-
6 fill all applicable requirements of the relevant
7 program.

8 “(B) DESCRIPTION OF GRANT PRO-
9 GRAMS.—A grant program referred to in sub-
10 paragraph (A) is a grant program—

11 “(i) administered by the Administra-
12 tion to fund activities relating to mental
13 health, suicide prevention, or suicide-re-
14 lated risk factors; and

15 “(ii) under which an Indian tribe or
16 tribal organization is an eligible recipient.

17 “(3) CLARIFICATION REGARDING INDIAN
18 TRIBES AND TRIBAL ORGANIZATIONS.—Notwith-
19 standing any other provision of law, in applying for
20 a grant under any program administered by the Ad-
21 ministration, no Indian tribe or tribal organization
22 shall be required to apply through a State or State
23 agency.

24 “(4) REQUIREMENTS FOR AFFECTED
25 STATES.—

1 “(A) DEFINITIONS.—In this paragraph:

2 “(i) AFFECTED STATE.—The term
3 ‘affected State’ means a State—

4 “(I) the boundaries of which in-
5 clude 1 or more Indian tribes; and

6 “(II) the application for a grant
7 under any program administered by
8 the Administration of which includes
9 statewide data.

10 “(ii) INDIAN POPULATION.—The term
11 ‘Indian population’ means the total num-
12 ber of residents of an affected State who
13 are Indian.

14 “(B) REQUIREMENTS.—As a condition of
15 receipt of a grant under any program adminis-
16 tered by the Administration, each affected State
17 shall—

18 “(i) describe in the grant applica-
19 tion—

20 “(I) the Indian population of the
21 affected State; and

22 “(II) the contribution of that In-
23 dian population to the statewide data
24 used by the affected State in the ap-
25 plication; and

1 “(ii) demonstrate to the satisfaction
2 of the Secretary that—

3 “(I) of the total amount of the
4 grant, the affected State will allocate
5 for use for the Indian population of
6 the affected State an amount equal to
7 the proportion that—

8 “(aa) the Indian population
9 of the affected State; bears to

10 “(bb) the total population of
11 the affected State; and

12 “(II) the affected State will take
13 reasonable efforts to collaborate with
14 each Indian tribe located within the
15 affected State to carry out youth sui-
16 cide prevention and treatment meas-
17 ures for members of the Indian tribe.

18 “(C) REPORT.—Not later than 1 year
19 after the date of receipt of a grant described in
20 subparagraph (B), an affected State shall sub-
21 mit to the Secretary a report describing the
22 measures carried out by the affected State to
23 ensure compliance with the requirements of
24 subparagraph (B)(ii).

1 “(b) NO NON-FEDERAL SHARE REQUIREMENT.—
2 Notwithstanding any other provision of law, no Indian
3 tribe or tribal organization shall be required to provide a
4 non-Federal share of the cost of any project or activity
5 carried out using a grant provided under any program ad-
6 ministered by the Administration.

7 “(c) OUTREACH FOR RURAL AND ISOLATED INDIAN
8 TRIBES.—Due to the rural, isolated nature of most Indian
9 reservations and communities (especially those reserva-
10 tions and communities in the Great Plains region), the
11 Secretary shall conduct outreach activities, with a par-
12 ticular emphasis on the provision of telemental health
13 services, to achieve the purposes of this subtitle with re-
14 spect to Indian tribes located in rural, isolated areas.

15 “(d) PROVISION OF OTHER ASSISTANCE.—

16 “(1) IN GENERAL.—The Secretary, acting
17 through the Administration, shall carry out such
18 measures (including monitoring and the provision of
19 required assistance) as the Secretary determines to
20 be necessary to ensure the provision of adequate sui-
21 cide prevention and mental health services to Indian
22 tribes described in paragraph (2), regardless of
23 whether those Indian tribes possess adequate per-
24 sonnel or infrastructure—

1 “(A) to submit an application for a grant
2 under any program administered by the Admin-
3 istration, including due to problems relating to
4 access to the Internet or other electronic means
5 that may have resulted in previous obstacles to
6 submission of a grant application; or

7 “(B) to fulfill all applicable requirements
8 of the relevant program.

9 “(2) DESCRIPTION OF INDIAN TRIBES.—An In-
10 dian tribe referred to in paragraph (1) is an Indian
11 tribe—

12 “(A) the members of which experience—

13 “(i) a high rate of youth suicide;

14 “(ii) low socioeconomic status; and

15 “(iii) extreme health disparity;

16 “(B) that is located in a remote and iso-
17 lated area; and

18 “(C) that lacks technology and commu-
19 nication infrastructure.

20 “(3) AUTHORIZATION OF APPROPRIATIONS.—

21 There are authorized to be appropriated to the Sec-
22 retary such sums as the Secretary determines to be
23 necessary to carry out this subsection.

24 “(e) EARLY INTERVENTION AND ASSESSMENT SERV-
25 ICES.—

1 “(1) DEFINITION OF AFFECTED ENTITY.—In
2 this subsection, the term ‘affected entity’ means any
3 entity—

4 “(A) that receives a grant for suicide inter-
5 vention, prevention, or treatment under a pro-
6 gram administered by the Administration; and

7 “(B) the population to be served by which
8 includes Indian youth.

9 “(2) REQUIREMENT.—The Secretary, acting
10 through the Administration, shall ensure that each
11 affected entity carrying out a youth suicide early
12 intervention and prevention strategy described in
13 section 520E(c)(1) of the Public Health Service Act
14 (42 U.S.C. 290bb–36(c)(1)), or any other youth sui-
15 cide-related early intervention and assessment activ-
16 ity, provides training or education to individuals who
17 interact frequently with the Indian youth to be
18 served by the affected entity (including parents,
19 teachers, coaches, and mentors) on identifying warn-
20 ing signs of Indian youth who are at risk of commit-
21 ting suicide.

22 **“SEC. 725. USE OF PREDOCTORAL PSYCHOLOGY AND PSY-**
23 **CHIATRY INTERNS.**

24 “The Secretary shall carry out such activities as the
25 Secretary determines to be necessary to encourage Indian

1 tribes, tribal organizations, and other mental health care
2 providers to obtain the services of predoctoral psychology
3 and psychiatry interns—

4 “(1) to increase the quantity of patients served
5 by the Indian tribes, tribal organizations, and other
6 mental health care providers; and

7 “(2) for purposes of recruitment and retention.

8 **“SEC. 726. INDIAN YOUTH LIFE SKILLS DEVELOPMENT**
9 **DEMONSTRATION PROGRAM.**

10 “(a) PURPOSE.—The purpose of this section is to au-
11 thorize the Secretary, acting through the Administration,
12 to carry out a demonstration program to test the effective-
13 ness of a culturally compatible, school-based, life skills
14 curriculum for the prevention of Indian and Alaska Native
15 adolescent suicide, including through—

16 “(1) the establishment of tribal partnerships to
17 develop and implement such a curriculum, in co-
18 operation with—

19 “(A) behavioral health professionals, with
20 a priority for tribal partnerships cooperating
21 with mental health professionals employed by
22 the Service;

23 “(B) tribal or local school agencies; and

24 “(C) parent and community groups;

1 “(2) the provision by the Administration or the
2 Service of—

3 “(A) technical expertise; and

4 “(B) clinicians, analysts, and educators, as
5 appropriate;

6 “(3) training for teachers, school administra-
7 tors, and community members to implement the cur-
8 riculum;

9 “(4) the establishment of advisory councils com-
10 posed of parents, educators, community members,
11 trained peers, and others to provide advice regarding
12 the curriculum and other components of the dem-
13 onstration program;

14 “(5) the development of culturally appropriate
15 support measures to supplement the effectiveness of
16 the curriculum; and

17 “(6) projects modeled after evidence-based
18 projects, such as programs evaluated and published
19 in relevant literature.

20 “(b) DEMONSTRATION GRANT PROGRAM.—

21 “(1) DEFINITIONS.—In this subsection:

22 “(A) CURRICULUM.—The term ‘cur-
23 riculum’ means the culturally compatible,
24 school-based, life skills curriculum for the pre-
25 vention of Indian and Alaska Native adolescent

1 suicide identified by the Secretary under para-
2 graph (2)(A).

3 “(B) ELIGIBLE ENTITY.—The term ‘eligi-
4 ble entity’ means—

5 “(i) an Indian tribe;

6 “(ii) a tribal organization;

7 “(iii) any other tribally authorized en-
8 tity; and

9 “(iv) any partnership composed of 2
10 or more entities described in clause (i), (ii),
11 or (iii).

12 “(2) ESTABLISHMENT.—The Secretary, acting
13 through the Administration, may establish and carry
14 out a demonstration program under which the Sec-
15 retary shall—

16 “(A) identify a culturally compatible,
17 school-based, life skills curriculum for the pre-
18 vention of Indian and Alaska Native adolescent
19 suicide;

20 “(B) identify the Indian tribes that are at
21 greatest risk for adolescent suicide;

22 “(C) invite those Indian tribes to partici-
23 pate in the demonstration program by—

1 “(i) responding to a comprehensive
2 program requirement request of the Sec-
3 retary; or

4 “(ii) submitting, through an eligible
5 entity, an application in accordance with
6 paragraph (4); and

7 “(D) provide grants to the Indian tribes
8 identified under subparagraph (B) and eligible
9 entities to implement the curriculum with re-
10 spect to Indian and Alaska Native youths
11 who—

12 “(i) are between the ages of 10 and
13 19; and

14 “(ii) attend school in a region that is
15 at risk of high youth suicide rates, as de-
16 termined by the Administration.

17 “(3) REQUIREMENTS.—

18 “(A) TERM.—The term of a grant pro-
19 vided under the demonstration program under
20 this section shall be not less than 4 years.

21 “(B) MAXIMUM NUMBER.—The Secretary
22 may provide not more than 5 grants under the
23 demonstration program under this section.

24 “(C) AMOUNT.—The grants provided
25 under this section shall be of equal amounts.

1 “(D) CERTAIN SCHOOLS.—In selecting eli-
2 gible entities to receive grants under this sec-
3 tion, the Secretary shall ensure that not less
4 than 1 demonstration program shall be carried
5 out at each of—

6 “(i) a school operated by the Bureau
7 of Indian Education;

8 “(ii) a Tribal school; and

9 “(iii) a school receiving payments
10 under section 8002 or 8003 of the Elemen-
11 tary and Secondary Education Act of 1965
12 (20 U.S.C. 7702, 7703).

13 “(4) APPLICATIONS.—To be eligible to receive a
14 grant under the demonstration program, an eligible
15 entity shall submit to the Secretary an application,
16 at such time, in such manner, and containing such
17 information as the Secretary may require, includ-
18 ing—

19 “(A) an assurance that, in implementing
20 the curriculum, the eligible entity will collabo-
21 rate with 1 or more local educational agencies,
22 including elementary schools, middle schools,
23 and high schools;

24 “(B) an assurance that the eligible entity
25 will collaborate, for the purpose of curriculum

development, implementation, and training and technical assistance, with 1 or more—

“(i) nonprofit entities with demonstrated expertise regarding the development of culturally sensitive, school-based, youth suicide prevention and intervention programs; or

“(ii) institutions of higher education with demonstrated interest and knowledge regarding culturally sensitive, school-based, life skills youth suicide prevention and intervention programs;

“(C) an assurance that the curriculum will be carried out in an academic setting in conjunction with at least 1 classroom teacher not less frequently than twice each school week for the duration of the academic year;

“(D) a description of the methods by which curriculum participants will be—

“(i) screened for mental health at-risk indicators; and

“(ii) if needed and on a case-by-case basis, referred to a mental health clinician for further assessment and treatment and with crisis response capability; and

“(E) an assurance that supportive services will be provided to curriculum participants identified as high-risk participants, including referral, counseling, and follow-up services for—

“(i) drug or alcohol abuse;

“(ii) sexual or domestic abuse; and

“(iii) depression and other relevant mental health concerns.

“(5) USE OF FUNDS.—An Indian tribe identified under paragraph (2)(B) or an eligible entity may use a grant provided under this subsection—

“(A) to develop and implement the curriculum in a school-based setting;

“(B) to establish an advisory council—

“(i) to advise the Indian tribe or eligible entity regarding curriculum development; and

“(ii) to provide support services identified as necessary by the community being served by the Indian tribe or eligible entity;

“(C) to appoint and train a school- and community-based cultural resource liaison, who will act as an intermediary among the Indian tribe or eligible entity, the applicable school ad-

1 ministrators, and the advisory council estab-
2 lished by the Indian tribe or eligible entity;

3 “(D) to establish an on-site, school-based,
4 MA- or Ph.D.-level mental health practitioner
5 (employed by the Service, if practicable) to
6 work with tribal educators and other personnel;

7 “(E) to provide for the training of peer
8 counselors to assist in carrying out the cur-
9 riculum;

10 “(F) to procure technical and training sup-
11 port from nonprofit or State entities or institu-
12 tions of higher education identified by the com-
13 munity being served by the Indian tribe or eligi-
14 ble entity as the best suited to develop and im-
15 plement the curriculum;

16 “(G) to train teachers and school adminis-
17 trators to effectively carry out the curriculum;

18 “(H) to establish an effective referral pro-
19 cedure and network;

20 “(I) to identify and develop culturally com-
21 patible curriculum support measures;

22 “(J) to obtain educational materials and
23 other resources from the Administration or
24 other appropriate entities to ensure the success
25 of the demonstration program; and

1 “(K) to evaluate the effectiveness of the
2 curriculum in preventing Indian and Alaska
3 Native adolescent suicide.

4 “(c) EVALUATIONS.—Using such amounts made
5 available pursuant to subsection (e) as the Secretary de-
6 termines to be appropriate, the Secretary shall conduct,
7 directly or through a grant, contract, or cooperative agree-
8 ment with an entity that has experience regarding the de-
9 velopment and operation of successful culturally compat-
10 ible, school-based, life skills suicide prevention and inter-
11 vention programs or evaluations, an annual evaluation of
12 the demonstration program under this section, including
13 an evaluation of—

14 “(1) the effectiveness of the curriculum in pre-
15 venting Indian and Alaska Native adolescent suicide;

16 “(2) areas for program improvement; and

17 “(3) additional development of the goals and
18 objectives of the demonstration program.

19 “(d) REPORT TO CONGRESS.—

20 “(1) IN GENERAL.—Subject to paragraph (2),
21 not later than 180 days after the date of termination
22 of the demonstration program, the Secretary shall
23 submit to the Committee on Indian Affairs and the
24 Committee on Health, Education, Labor, and Pen-
25 sions of the Senate and the Committee on Natural

1 Resources and the Committee on Education and
2 Labor of the House of Representatives a final report
3 that—

4 “(A) describes the results of the program
5 of each Indian tribe or eligible entity under this
6 section;

7 “(B) evaluates the effectiveness of the cur-
8 riculum in preventing Indian and Alaska Native
9 adolescent suicide;

10 “(C) makes recommendations regarding—

11 “(i) the expansion of the demonstra-
12 tion program under this section to addi-
13 tional eligible entities;

14 “(ii) designating the demonstration
15 program as a permanent program; and

16 “(iii) identifying and distributing the
17 curriculum through the Suicide Prevention
18 Resource Center of the Administration;
19 and

20 “(D) incorporates any public comments re-
21 ceived under paragraph (2).

22 “(2) PUBLIC COMMENT.—The Secretary shall
23 provide a notice of the report under paragraph (1)
24 and an opportunity for public comment on the re-

1 port for a period of not less than 90 days before
 2 submitting the report to Congress.

3 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 4 is authorized to be appropriated to carry out this section
 5 \$1,000,000 for each of fiscal years 2017 through 2020.”.

6 **Subtitle H—Miscellaneous**

7 **SEC. 191. CONFIDENTIALITY OF MEDICAL QUALITY ASSUR-** 8 **ANCE RECORDS; QUALIFIED IMMUNITY FOR** 9 **PARTICIPANTS.**

10 Title VIII of the Indian Health Care Improvement
 11 Act (as amended by section 101(b)) is amended by insert-
 12 ing after section 804 (25 U.S.C. 1674) the following:

13 **“SEC. 805. CONFIDENTIALITY OF MEDICAL QUALITY ASSUR-** 14 **ANCE RECORDS; QUALIFIED IMMUNITY FOR** 15 **PARTICIPANTS.**

16 “(a) DEFINITIONS.—In this section:

17 “(1) HEALTH CARE PROVIDER.—The term
 18 ‘health care provider’ means any health care profes-
 19 sional, including community health aides and practi-
 20 tioners certified under section 119, who is—

21 “(A) granted clinical practice privileges or
 22 employed to provide health care services at—

23 “(i) an Indian health program; or

24 “(ii) a health program of an urban In-
 25 dian organization; and

1 “(B) licensed or certified to perform health
2 care services by a governmental board or agen-
3 cy or professional health care society or organi-
4 zation.

5 “(2) MEDICAL QUALITY ASSURANCE PRO-
6 GRAM.—The term ‘medical quality assurance pro-
7 gram’ means any activity carried out before, on, or
8 after the date of enactment of the Indian Healthcare
9 Improvement Act of 2017 by or for any Indian
10 health program or urban Indian organization to as-
11 sess the quality of medical care, including activities
12 conducted by or on behalf of individuals, Indian
13 health program or urban Indian organization med-
14 ical or dental treatment review committees, or other
15 review bodies responsible for quality assurance, cre-
16 dentials, infection control, patient safety, patient
17 care assessment (including treatment procedures,
18 blood, drugs, and therapeutics), medical records,
19 health resources management review, and identifica-
20 tion and prevention of medical or dental incidents
21 and risks.

22 “(3) MEDICAL QUALITY ASSURANCE RECORD.—
23 The term ‘medical quality assurance record’ means
24 the proceedings, records, minutes, and reports
25 that—

1 “(A) emanate from quality assurance pro-
2 gram activities described in paragraph (2); and

3 “(B) are produced or compiled by or for an
4 Indian health program or urban Indian organi-
5 zation as part of a medical quality assurance
6 program.

7 “(b) CONFIDENTIALITY OF RECORDS.—Medical qual-
8 ity assurance records created by or for any Indian health
9 program or a health program of an urban Indian organiza-
10 tion as part of a medical quality assurance program are
11 confidential and privileged. Such records may not be dis-
12 closed to any person or entity, except as provided in sub-
13 section (d).

14 “(c) PROHIBITION ON DISCLOSURE AND TESTI-
15 MONY.—

16 “(1) IN GENERAL.—No part of any medical
17 quality assurance record described in subsection (b)
18 may be subject to discovery or admitted into evi-
19 dence in any judicial or administrative proceeding,
20 except as provided in subsection (d).

21 “(2) TESTIMONY.—An individual who reviews
22 or creates medical quality assurance records for any
23 Indian health program or urban Indian organization
24 who participates in any proceeding that reviews or
25 creates such records may not be permitted or re-

1 quired to testify in any judicial or administrative
2 proceeding with respect to such records or with re-
3 spect to any finding, recommendation, evaluation,
4 opinion, or action taken by such person or body in
5 connection with such records except as provided in
6 this section.

7 “(d) AUTHORIZED DISCLOSURE AND TESTIMONY.—

8 “(1) IN GENERAL.—Subject to paragraph (2), a
9 medical quality assurance record described in sub-
10 section (b) may be disclosed, and an individual re-
11 ferred to in subsection (c) may give testimony in
12 connection with such a record, only as follows:

13 “(A) To a Federal agency or private orga-
14 nization, if such medical quality assurance
15 record or testimony is needed by such agency or
16 organization to perform licensing or accredita-
17 tion functions related to any Indian health pro-
18 gram or to a health program of an urban In-
19 dian organization to perform monitoring, re-
20 quired by law, of such program or organization.

21 “(B) To an administrative or judicial pro-
22 ceeding commenced by a present or former In-
23 dian health program or urban Indian organiza-
24 tion provider concerning the termination, sus-

1 pension, or limitation of clinical privileges of
2 such health care provider.

3 “(C) To a governmental board or agency
4 or to a professional health care society or orga-
5 nization, if such medical quality assurance
6 record or testimony is needed by such board,
7 agency, society, or organization to perform li-
8 censing, credentialing, or the monitoring of pro-
9 fessional standards with respect to any health
10 care provider who is or was an employee of any
11 Indian health program or urban Indian organi-
12 zation.

13 “(D) To a hospital, medical center, or
14 other institution that provides health care serv-
15 ices, if such medical quality assurance record or
16 testimony is needed by such institution to as-
17 sess the professional qualifications of any health
18 care provider who is or was an employee of any
19 Indian health program or urban Indian organi-
20 zation and who has applied for or been granted
21 authority or employment to provide health care
22 services in or on behalf of such program or or-
23 ganization.

24 “(E) To an officer, employee, or contractor
25 of the Indian health program or urban Indian

1 organization that created the records or for
2 which the records were created. If that officer,
3 employee, or contractor has a need for such
4 record or testimony to perform official duties.

5 “(F) To a criminal or civil law enforce-
6 ment agency or instrumentality charged under
7 applicable law with the protection of the public
8 health or safety, if a qualified representative of
9 such agency or instrumentality makes a written
10 request that such record or testimony be pro-
11 vided for a purpose authorized by law.

12 “(G) In an administrative or judicial pro-
13 ceeding commenced by a criminal or civil law
14 enforcement agency or instrumentality referred
15 to in subparagraph (F), but only with respect
16 to the subject of such proceeding.

17 “(2) IDENTITY OF PARTICIPANTS.—With the
18 exception of the subject of a quality assurance ac-
19 tion, the identity of any person receiving health care
20 services from any Indian health program or urban
21 Indian organization or the identity of any other per-
22 son associated with such program or organization
23 for purposes of a medical quality assurance program
24 that is disclosed in a medical quality assurance
25 record described in subsection (b) shall be deleted

1 from that record or document before any disclosure
2 of such record is made outside such program or or-
3 ganization.

4 “(e) DISCLOSURE FOR CERTAIN PURPOSES.—

5 “(1) IN GENERAL.—Nothing in this section
6 shall be construed as authorizing or requiring the
7 withholding from any person or entity aggregate sta-
8 tistical information regarding the results of any In-
9 dian health program or urban Indian organization’s
10 medical quality assurance programs.

11 “(2) WITHHOLDING FROM CONGRESS.—Noth-
12 ing in this section shall be construed as authority to
13 withhold any medical quality assurance record from
14 a committee of either House of Congress, any joint
15 committee of Congress, or the Government Account-
16 ability Office if such record pertains to any matter
17 within their respective jurisdictions.

18 “(f) PROHIBITION ON DISCLOSURE OF RECORD OR
19 TESTIMONY.—An individual or entity having possession of
20 or access to a record or testimony described by this section
21 may not disclose the contents of such record or testimony
22 in any manner or for any purpose except as provided in
23 this section.

24 “(g) EXEMPTION FROM FREEDOM OF INFORMATION
25 ACT.—Medical quality assurance records described in sub-

1 section (b) may not be made available to any person under
2 section 552 of title 5, United States Code.

3 “(h) LIMITATION ON CIVIL LIABILITY.—An indi-
4 vidual who participates in or provides information to a
5 person or body that reviews or creates medical quality as-
6 surance records described in subsection (b) shall not be
7 civilly liable for such participation or for providing such
8 information if the participation or provision of information
9 was in good faith based on prevailing professional stand-
10 ards at the time the medical quality assurance program
11 activity took place.

12 “(i) APPLICATION TO INFORMATION IN CERTAIN
13 OTHER RECORDS.—Nothing in this section shall be con-
14 strued as limiting access to the information in a record
15 created and maintained outside a medical quality assur-
16 ance program, including a patient’s medical records, on
17 the grounds that the information was presented during
18 meetings of a review body that are part of a medical qual-
19 ity assurance program.

20 “(j) REGULATIONS.—The Secretary, acting through
21 the Service, shall promulgate regulations pursuant to sec-
22 tion 802.

23 “(k) CONTINUED PROTECTION.—Disclosure under
24 subsection (d) does not permit redisclosure except to the
25 extent such further disclosure is authorized under sub-

1 section (d) or is otherwise authorized to be disclosed under
2 this section.

3 “(l) INCONSISTENCIES.—To the extent that the pro-
4 tections under part C of title IX of the Public Health Serv-
5 ice Act (42 U.S.C. 229b–21 et seq.) (as amended by the
6 Patient Safety and Quality Improvement Act of 2005
7 (Public Law 109–41; 119 Stat. 424)) and this section are
8 inconsistent, the provisions of whichever is more protective
9 shall control.

10 “(m) RELATIONSHIP TO OTHER LAW.—This section
11 shall continue in force and effect, except as otherwise spe-
12 cifically provided in any Federal law enacted after the date
13 of enactment of the Indian Healthcare Improvement Act
14 of 2017.”.

15 **SEC. 192. LIMITATION ON USE OF FUNDS APPROPRIATED**
16 **TO THE INDIAN HEALTH SERVICE.**

17 Section 806 of the Indian Health Care Improvement
18 Act is amended—

19 (1) by striking “Any limitation” and inserting
20 the following:

21 “(a) HHS APPROPRIATIONS.—Any limitation”; and

22 (2) by adding at the end the following:

23 “(b) LIMITATIONS PURSUANT TO OTHER FEDERAL
24 LAW.—Any limitation pursuant to other Federal laws on
25 the use of Federal funds appropriated to the Service shall

1 apply with respect to the performance or coverage of abor-
2 tions.”.

3 **SEC. 193. ARIZONA, NORTH DAKOTA, AND SOUTH DAKOTA**
4 **AS CONTRACT HEALTH SERVICE DELIVERY**
5 **AREAS; ELIGIBILITY OF CALIFORNIA INDI-**
6 **ANS.**

7 Title VIII of the Indian Health Care Improvement
8 Act is amended—

9 (1) by striking section 808 (25 U.S.C. 1678)
10 and inserting the following:

11 **“SEC. 808. ARIZONA AS CONTRACT HEALTH SERVICE DELIV-**
12 **ERY AREA.**

13 “(a) IN GENERAL.—The State of Arizona shall be
14 designated as a contract health service delivery area by
15 the Service for the purpose of providing contract health
16 care services to members of Indian tribes in the State of
17 Arizona.

18 “(b) MAINTENANCE OF SERVICES.—The Service
19 shall not curtail any health care services provided to Indi-
20 ans residing on reservations in the State of Arizona if the
21 curtailment is due to the provision of contract services in
22 that State pursuant to the designation of the State as a
23 contract health service delivery area by subsection (a).”;

24 (2) by inserting after section 808 (25 U.S.C.
25 1678) the following:

1 **“SEC. 808A. NORTH DAKOTA AND SOUTH DAKOTA AS CON-**
2 **TRACT HEALTH SERVICE DELIVERY AREA.**

3 “(a) IN GENERAL.—The States of North Dakota and
4 South Dakota shall be designated as a contract health
5 service delivery area by the Service for the purpose of pro-
6 viding contract health care services to members of Indian
7 tribes in the States of North Dakota and South Dakota.

8 “(b) MAINTENANCE OF SERVICES.—The Service
9 shall not curtail any health care services provided to Indi-
10 ans residing on any reservation, or in any county that has
11 a common boundary with any reservation, in the State of
12 North Dakota or South Dakota if the curtailment is due
13 to the provision of contract services in those States pursu-
14 ant to the designation of the States as a contract health
15 service delivery area by subsection (a).”; and

16 (3) by striking section 809 (25 U.S.C. 1679)
17 and inserting the following:

18 **“SEC. 809. ELIGIBILITY OF CALIFORNIA INDIANS.**

19 “(a) IN GENERAL.—The following California Indians
20 shall be eligible for health services provided by the Service:

21 “(1) Any member of a federally recognized In-
22 dian tribe.

23 “(2) Any descendant of an Indian who was re-
24 siding in California on June 1, 1852, if such de-
25 scendant—

1 “(A) is a member of the Indian community
2 served by a local program of the Service; and

3 “(B) is regarded as an Indian by the com-
4 munity in which such descendant lives.

5 “(3) Any Indian who holds trust interests in
6 public domain, national forest, or reservation allot-
7 ments in California.

8 “(4) Any Indian of California who is listed on
9 the plans for distribution of the assets of rancherias
10 and reservations located within the State of Cali-
11 fornia under the Act of August 18, 1958 (72 Stat.
12 619), and any descendant of such an Indian.

13 “(b) CLARIFICATION.—Nothing in this section may
14 be construed as expanding the eligibility of California Indi-
15 ans for health services provided by the Service beyond the
16 scope of eligibility for such health services that applied on
17 May 1, 1986.”.

18 **SEC. 194. METHODS TO INCREASE ACCESS TO PROFES-**
19 **SIONALS OF CERTAIN CORPS.**

20 Section 812 of the Indian Health Care Improvement
21 Act (25 U.S.C. 1680b) is amended to read as follows:

22 **“SEC. 812. NATIONAL HEALTH SERVICE CORPS.**

23 “(a) NO REDUCTION IN SERVICES.—The Secretary
24 shall not remove a member of the National Health Service
25 Corps from an Indian health program or urban Indian or-

1 ganization or withdraw funding used to support such a
2 member, unless the Secretary, acting through the Service,
3 has ensured that the Indians receiving services from the
4 member will experience no reduction in services.

5 “(b) TREATMENT OF INDIAN HEALTH PROGRAMS.—
6 At the request of an Indian health program, the services
7 of a member of the National Health Service Corps as-
8 signed to the Indian health program may be limited to
9 the individuals who are eligible for services from that In-
10 dian health program.”.

11 **SEC. 195. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

12 Section 813 of the Indian Health Care Improvement
13 Act (25 U.S.C. 1680c) is amended to read as follows:

14 **“SEC. 813. HEALTH SERVICES FOR INELIGIBLE PERSONS.**

15 “(a) CHILDREN.—Any individual who—

16 “(1) has not attained 19 years of age;

17 “(2) is the natural or adopted child, stepchild,
18 foster child, legal ward, or orphan of an eligible In-
19 dian; and

20 “(3) is not otherwise eligible for health services
21 provided by the Service,

22 shall be eligible for all health services provided by the
23 Service on the same basis and subject to the same rules
24 that apply to eligible Indians until such individual attains
25 19 years of age. The existing and potential health needs

1 of all such individuals shall be taken into consideration
2 by the Service in determining the need for, or the alloca-
3 tion of, the health resources of the Service. If such an indi-
4 vidual has been determined to be legally incompetent prior
5 to attaining 19 years of age, such individual shall remain
6 eligible for such services until 1 year after the date of a
7 determination of competency.

8 “(b) SPOUSES.—Any spouse of an eligible Indian who
9 is not an Indian, or who is of Indian descent but is not
10 otherwise eligible for the health services provided by the
11 Service, shall be eligible for such health services if all such
12 spouses or spouses who are married to members of each
13 Indian tribe being served are made eligible, as a class, by
14 an appropriate resolution of the governing body of the In-
15 dian tribe or tribal organization providing such services.
16 The health needs of persons made eligible under this para-
17 graph shall not be taken into consideration by the Service
18 in determining the need for, or allocation of, its health
19 resources.

20 “(c) HEALTH FACILITIES PROVIDING HEALTH
21 SERVICES.—

22 “(1) IN GENERAL.—The Secretary is authorized
23 to provide health services under this subsection
24 through health facilities operated directly by the
25 Service to individuals who reside within the Service

1 unit and who are not otherwise eligible for such
2 health services if—

3 “(A) the Indian tribes served by such Serv-
4 ice unit requests such provision of health serv-
5 ices to such individuals, and

6 “(B) the Secretary and the served Indian
7 tribes have jointly determined that the provision
8 of such health services will not result in a de-
9 nial or diminution of health services to eligible
10 Indians.

11 “(2) ISDEAA PROGRAMS.—In the case of
12 health facilities operated under a contract or com-
13 pact entered into under the Indian Self-Determina-
14 tion and Education Assistance Act (25 U.S.C. 450
15 et seq.), the governing body of the Indian tribe or
16 tribal organization providing health services under
17 such contract or compact is authorized to determine
18 whether health services should be provided under
19 such contract or compact to individuals who are not
20 eligible for such health services under any other sub-
21 section of this section or under any other provision
22 of law. In making such determinations, the gov-
23 erning body of the Indian tribe or tribal organization
24 shall take into account the consideration described in
25 paragraph (1)(B). Any services provided by the In-

1 dian tribe or tribal organization pursuant to a deter-
2 mination made under this subparagraph shall be
3 deemed to be provided under the agreement entered
4 into by the Indian tribe or tribal organization under
5 the Indian Self-Determination and Education Assist-
6 ance Act. The provisions of section 314 of Public
7 Law 101–512 (104 Stat. 1959), as amended by sec-
8 tion 308 of Public Law 103–138 (107 Stat. 1416),
9 shall apply to any services provided by the Indian
10 tribe or tribal organization pursuant to a determina-
11 tion made under this subparagraph.

12 “(3) PAYMENT FOR SERVICES.—

13 “(A) IN GENERAL.—Persons receiving
14 health services provided by the Service under
15 this subsection shall be liable for payment of
16 such health services under a schedule of charges
17 prescribed by the Secretary which, in the judg-
18 ment of the Secretary, results in reimbursement
19 in an amount not less than the actual cost of
20 providing the health services. Notwithstanding
21 section 207 of this Act or any other provision
22 of law, amounts collected under this subsection,
23 including Medicare, Medicaid, or children’s
24 health insurance program reimbursements
25 under titles XVIII, XIX, and XXI of the Social

1 Security Act (42 U.S.C. 1395 et seq.), shall be
2 credited to the account of the program pro-
3 viding the service and shall be used for the pur-
4 poses listed in section 401(d)(2) and amounts
5 collected under this subsection shall be available
6 for expenditure within such program.

7 “(B) INDIGENT PEOPLE.—Health services
8 may be provided by the Secretary through the
9 Service under this subsection to an indigent in-
10 dividual who would not be otherwise eligible for
11 such health services but for the provisions of
12 paragraph (1) only if an agreement has been
13 entered into with a State or local government
14 under which the State or local government
15 agrees to reimburse the Service for the expenses
16 incurred by the Service in providing such health
17 services to such indigent individual.

18 “(4) REVOCATION OF CONSENT FOR SERV-
19 ICES.—

20 “(A) SINGLE TRIBE SERVICE AREA.—In
21 the case of a Service Area which serves only 1
22 Indian tribe, the authority of the Secretary to
23 provide health services under paragraph (1)
24 shall terminate at the end of the fiscal year suc-
25 ceeding the fiscal year in which the governing

1 body of the Indian tribe revokes its concurrence
2 to the provision of such health services.

3 “(B) MULTITRIBAL SERVICE AREA.—In
4 the case of a multitribal Service Area, the au-
5 thority of the Secretary to provide health serv-
6 ices under paragraph (1) shall terminate at the
7 end of the fiscal year succeeding the fiscal year
8 in which at least 51 percent of the number of
9 Indian tribes in the Service Area revoke their
10 concurrence to the provisions of such health
11 services.

12 “(d) OTHER SERVICES.—The Service may provide
13 health services under this subsection to individuals who
14 are not eligible for health services provided by the Service
15 under any other provision of law in order to—

16 “(1) achieve stability in a medical emergency;
17 “(2) prevent the spread of a communicable dis-
18 ease or otherwise deal with a public health hazard;
19 “(3) provide care to non-Indian women preg-
20 nant with an eligible Indian’s child for the duration
21 of the pregnancy through postpartum; or
22 “(4) provide care to immediate family members
23 of an eligible individual if such care is directly re-
24 lated to the treatment of the eligible individual.

25 “(e) HOSPITAL PRIVILEGES FOR PRACTITIONERS.—

1 “(1) IN GENERAL.—Hospital privileges in
2 health facilities operated and maintained by the
3 Service or operated under a contract or compact
4 pursuant to the Indian Self-Determination and Edu-
5 cation Assistance Act (25 U.S.C. 450 et seq.) may
6 be extended to non-Service health care practitioners
7 who provide services to individuals described in sub-
8 section (a), (b), (c), or (d). Such non-Service health
9 care practitioners may, as part of the privileging
10 process, be designated as employees of the Federal
11 Government for purposes of section 1346(b) and
12 chapter 171 of title 28, United States Code (relating
13 to Federal tort claims) only with respect to acts or
14 omissions which occur in the course of providing
15 services to eligible individuals as a part of the condi-
16 tions under which such hospital privileges are ex-
17 tended.

18 “(2) DEFINITION.—For purposes of this sub-
19 section, the term ‘non-Service health care practi-
20 tioner’ means a practitioner who is not—

21 “(A) an employee of the Service; or

22 “(B) an employee of an Indian tribe or
23 tribal organization operating a contract or com-
24 pact under the Indian Self-Determination and
25 Education Assistance Act (25 U.S.C. 450 et

1 seq.) or an individual who provides health care
2 services pursuant to a personal services con-
3 tract with such Indian tribe or tribal organiza-
4 tion.

5 “(f) ELIGIBLE INDIAN.—For purposes of this sec-
6 tion, the term ‘eligible Indian’ means any Indian who is
7 eligible for health services provided by the Service without
8 regard to the provisions of this section.”.

9 **SEC. 196. ANNUAL BUDGET SUBMISSION.**

10 Title VIII of the Indian Health Care Improvement
11 Act (25 U.S.C. 1671 et seq.) is amended by adding at
12 the end the following:

13 **“SEC. 826. ANNUAL BUDGET SUBMISSION.**

14 “Effective beginning with the submission of the an-
15 nual budget request to Congress for fiscal year 2017, the
16 President shall include, in the amount requested and the
17 budget justification, amounts that reflect any changes
18 in—

19 “(1) the cost of health care services, as indexed
20 for United States dollar inflation (as measured by
21 the Consumer Price Index); and

22 “(2) the size of the population served by the
23 Service.”.

1 **SEC. 197. PRESCRIPTION DRUG MONITORING.**

2 Title VIII of the Indian Health Care Improvement
3 Act (25 U.S.C. 1671 et seq.) (as amended by section 195)
4 is amended by adding at the end the following:

5 **“SEC. 827. PRESCRIPTION DRUG MONITORING.**

6 **“(a) MONITORING.—**

7 **“(1) ESTABLISHMENT.—**The Secretary, in co-
8 ordination with the Secretary of the Interior and the
9 Attorney General, shall establish a prescription drug
10 monitoring program, to be carried out at health care
11 facilities of the Service, tribal health care facilities,
12 and urban Indian health care facilities.

13 **“(2) REPORT.—**Not later than 18 months after
14 the date of enactment of the Indian Healthcare Im-
15 provement Act of 2017, the Secretary shall submit
16 to the Committee on Indian Affairs of the Senate
17 and the Committee on Natural Resources of the
18 House of Representatives a report that describes—

19 **“(A)** the needs of the Service, tribal health
20 care facilities, and urban Indian health care fa-
21 cilities with respect to the prescription drug
22 monitoring program under paragraph (1);

23 **“(B)** the planned development of that pro-
24 gram, including any relevant statutory or ad-
25 ministrative limitations; and

1 “(C) the means by which the program
2 could be carried out in coordination with any
3 State prescription drug monitoring program.

4 “(b) ABUSE.—

5 “(1) IN GENERAL.—The Attorney General, in
6 conjunction with the Secretary and the Secretary of
7 the Interior, shall conduct—

8 “(A) an assessment of the capacity of, and
9 support required by, relevant Federal and tribal
10 agencies—

11 “(i) to carry out data collection and
12 analysis regarding incidents of prescription
13 drug abuse in Indian communities; and

14 “(ii) to exchange among those agen-
15 cies and Indian health programs informa-
16 tion relating to prescription drug abuse in
17 Indian communities, including statutory
18 and administrative requirements and limi-
19 tations relating to that abuse; and

20 “(B) training for Indian health care pro-
21 viders, tribal leaders, law enforcement officers,
22 and school officials regarding awareness and
23 prevention of prescription drug abuse and strat-
24 egies for improving agency responses to ad-

1 dressing prescription drug abuse in Indian com-
2 munities.

3 “(2) REPORT.—Not later than 18 months after
4 the date of enactment of the Indian Healthcare Im-
5 provement Act of 2017, the Attorney General shall
6 submit to the Committee on Indian Affairs of the
7 Senate and the Committee on Natural Resources of
8 the House of Representatives a report that de-
9 scribes—

10 “(A) the capacity of Federal and tribal
11 agencies to carry out data collection and anal-
12 ysis and information exchanges as described in
13 paragraph (1)(A);

14 “(B) the training conducted pursuant to
15 paragraph (1)(B);

16 “(C) infrastructure enhancements required
17 to carry out the activities described in para-
18 graph (1), if any; and

19 “(D) any statutory or administrative bar-
20 riers to carrying out those activities.”.

21 **SEC. 198. TRIBAL HEALTH PROGRAM OPTION FOR COST**
22 **SHARING.**

23 Title VIII of the Indian Health Care Improvement
24 Act (25 U.S.C. 1671 et seq.) (as amended by section 196)
25 is amended by adding at the end the following:

1 **“SEC. 828. TRIBAL HEALTH PROGRAM OPTION FOR COST**
 2 **SHARING.**

3 “(a) IN GENERAL.—Nothing in this Act limits the
 4 ability of a tribal health program operating any health
 5 program, service, function, activity, or facility funded, in
 6 whole or part, by the Service through, or provided for in,
 7 a compact with the Service pursuant to title V of the In-
 8 dian Self-Determination and Education Assistance Act
 9 (25 U.S.C. 458aaa et seq.) to charge an Indian for serv-
 10 ices provided by the tribal health program.

11 “(b) SERVICE.—Nothing in this Act authorizes the
 12 Service—

13 “(1) to charge an Indian for services; or

14 “(2) to require any tribal health program to
 15 charge an Indian for services.”.

16 **SEC. 199. DISEASE AND INJURY PREVENTION REPORT.**

17 Title VIII of the Indian Health Care Improvement
 18 Act (25 U.S.C. 1671 et seq.) (as amended by section 197)
 19 is amended by adding at the end the following:

20 **“SEC. 829. DISEASE AND INJURY PREVENTION REPORT.**

21 “Not later than 18 months after the date of enact-
 22 ment of the Indian Healthcare Improvement Act of 2017,
 23 the Secretary shall submit to the Committee on Indian Af-
 24 fairs of the Senate and the Committees on Natural Re-
 25 sources and Energy and Commerce of the House of Rep-
 26 resentatives describing—

1 “(1) all disease and injury prevention activities
 2 conducted by the Service, independently or in con-
 3 junction with other Federal departments and agen-
 4 cies and Indian tribes; and

5 “(2) the effectiveness of those activities, includ-
 6 ing the reductions of injury or disease conditions
 7 achieved by the activities.”.

8 **SEC. 200. OTHER GAO REPORTS.**

9 Title VIII of the Indian Health Care Improvement
 10 Act (25 U.S.C. 1671 et seq.) (as amended by section 198)
 11 is amended by adding at the end the following:

12 **“SEC. 830. OTHER GAO REPORTS.**

13 “(a) COORDINATION OF SERVICES.—

14 “(1) STUDY AND EVALUATION.—The Comp-
 15 troller General of the United States shall conduct a
 16 study, and evaluate the effectiveness, of coordination
 17 of health care services provided to Indians—

18 “(A) through Medicare, Medicaid, or
 19 SCHIP;

20 “(B) by the Service; or

21 “(C) using funds provided by—

22 “(i) State or local governments; or

23 “(ii) Indian tribes.

24 “(2) REPORT.—Not later than 18 months after
 25 the date of enactment of the Indian Healthcare Im-

1 provement Act of 2017, the Comptroller General
2 shall submit to Congress a report—

3 “(A) describing the results of the evalua-
4 tion under paragraph (1); and

5 “(B) containing recommendations of the
6 Comptroller General regarding measures to
7 support and increase coordination of the provi-
8 sion of health care services to Indians as de-
9 scribed in paragraph (1).

10 “(b) PAYMENTS FOR CONTRACT HEALTH SERV-
11 ICES.—

12 “(1) IN GENERAL.—The Comptroller General
13 shall conduct a study on the use of health care fur-
14 nished by health care providers under the contract
15 health services program funded by the Service and
16 operated by the Service, an Indian tribe, or a tribal
17 organization.

18 “(2) ANALYSIS.—The study conducted under
19 paragraph (1) shall include an analysis of—

20 “(A) the amounts reimbursed under the
21 contract health services program described in
22 paragraph (1) for health care furnished by enti-
23 ties, individual providers, and suppliers, includ-
24 ing a comparison of reimbursement for that

1 health care through other public programs and
2 in the private sector;

3 “(B) barriers to accessing care under such
4 contract health services program, including bar-
5 riers relating to travel distances, cultural dif-
6 ferences, and public and private sector reluc-
7 tance to furnish care to patients under the pro-
8 gram;

9 “(C) the adequacy of existing Federal
10 funding for health care under the contract
11 health services program;

12 “(D) the administration of the contract
13 health service program, including the distribu-
14 tion of funds to Indian health programs pursu-
15 ant to the program; and

16 “(E) any other items determined appro-
17 priate by the Comptroller General.

18 “(3) REPORT.—Not later than 18 months after
19 the date of enactment of the Indian Healthcare Im-
20 provement Act of 2017, the Comptroller General
21 shall submit to Congress a report on the study con-
22 ducted under paragraph (1), together with rec-
23 ommendations regarding—

24 “(A) the appropriate level of Federal fund-
25 ing that should be established for health care

1 under the contract health services program de-
2 scribed in paragraph (1);

3 “(B) how to most efficiently use that fund-
4 ing; and

5 “(C) the identification of any inequities in
6 the current distribution formula or inequitable
7 results for any Indian tribe under the funding
8 level, and any recommendations for addressing
9 any inequities or inequitable results identified.

10 “(4) CONSULTATION.—In conducting the study
11 under paragraph (1) and preparing the report under
12 paragraph (3), the Comptroller General shall consult
13 with the Service, Indian tribes, and tribal organiza-
14 tions.”.

15 **SEC. 201. TRADITIONAL HEALTH CARE PRACTICES.**

16 Title VIII of the Indian Health Care Improvement
17 Act (25 U.S.C. 1671 et seq.) (as amended by section 199)
18 is amended by adding at the end the following:

19 **“SEC. 831. TRADITIONAL HEALTH CARE PRACTICES.**

20 “Although the Secretary may promote traditional
21 health care practices, consistent with the Service stand-
22 ards for the provision of health care, health promotion,
23 and disease prevention under this Act, the United States
24 is not liable for any provision of traditional health care
25 practices pursuant to this Act that results in damage, in-

1 jury, or death to a patient. Nothing in this subsection shall
 2 be construed to alter any liability or other obligation that
 3 the United States may otherwise have under the Indian
 4 Self-Determination and Education Assistance Act (25
 5 U.S.C. 450 et seq.) or this Act.”.

6 **SEC. 202. DIRECTOR OF HIV/AIDS PREVENTION AND TREAT-**
 7 **MENT.**

8 Title VIII of the Indian Health Care Improvement
 9 Act (25 U.S.C. 1671 et seq.) (as amended by section
 10 199A) is amended by adding at the end the following:

11 **“SEC. 832. DIRECTOR OF HIV/AIDS PREVENTION AND**
 12 **TREATMENT.**

13 “(a) ESTABLISHMENT.—The Secretary, acting
 14 through the Service, shall establish within the Service the
 15 position of the Director of HIV/AIDS Prevention and
 16 Treatment (referred to in this section as the ‘Director’).

17 “(b) DUTIES.—The Director shall—

18 “(1) coordinate and promote HIV/AIDS preven-
 19 tion and treatment activities specific to Indians;

20 “(2) provide technical assistance to Indian
 21 tribes, tribal organizations, and urban Indian orga-
 22 nizations regarding existing HIV/AIDS prevention
 23 and treatment programs; and

24 “(3) ensure interagency coordination to facili-
 25 tate the inclusion of Indians in Federal HIV/AIDS

1 research and grant opportunities, with emphasis on
2 the programs operated under the Ryan White Com-
3 prehensive Aids Resources Emergency Act of 1990
4 (Public Law 101–381; 104 Stat. 576) and the
5 amendments made by that Act.

6 “(c) REPORT.—Not later than 2 years after the date
7 of enactment of the Indian Healthcare Improvement Act
8 of 2017, and not less frequently than once every 2 years
9 thereafter, the Director shall submit to Congress a report
10 describing, with respect to the preceding 2-year period—

11 “(1) each activity carried out under this sec-
12 tion; and

13 “(2) any findings of the Director with respect
14 to HIV/AIDS prevention and treatment activities
15 specific to Indians.”.

16 **TITLE II—AMENDMENTS TO**
17 **OTHER ACTS AND MISCELLA-**
18 **NEOUS PROVISIONS**

19 **SEC. 201. ELIMINATION OF SUNSET FOR REIMBURSEMENT**
20 **FOR ALL MEDICARE PART B SERVICES FUR-**
21 **NISHED BY CERTAIN INDIAN HOSPITALS AND**
22 **CLINICS.**

23 (a) REIMBURSEMENT FOR ALL MEDICARE PART B
24 SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS
25 AND CLINICS.—Section 1880(e)(1)(A) of the Social Secu-

1 rity Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by strik-
 2 ing “during the 5-year period beginning on” and inserting
 3 “on or after”.

4 (b) EFFECTIVE DATE.—The amendments made by
 5 this section shall apply to items or services furnished on
 6 or after January 1, 2017.

7 **SEC. 202. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**
 8 **SISTANCE PROGRAMS AND INDIAN HEALTH**
 9 **SERVICE IN PROVIDING PRESCRIPTION**
 10 **DRUGS TOWARD THE ANNUAL OUT-OF-POCK-**
 11 **ET THRESHOLD UNDER PART D.**

12 (a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the
 13 Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is
 14 amended—

15 (1) in clause (i), by striking “and” at the end;

16 (2) in clause (ii)—

17 (A) by striking “such costs shall be treated
 18 as incurred only if” and inserting “subject to
 19 clause (iii), such costs shall be treated as in-
 20 curred only if”;

21 (B) by striking “, under section 1860D–
 22 14, or under a State Pharmaceutical Assistance
 23 Program”; and

24 (C) by striking the period at the end and
 25 inserting “; and”; and

1 (3) by inserting after clause (ii) the following
2 new clause:

3 “(iii) such costs shall be treated as in-
4 curred and shall not be considered to be
5 reimbursed under clause (ii) if such costs
6 are borne or paid—

7 “(I) under section 1860D–14;

8 “(II) under a State Pharma-
9 ceutical Assistance Program;

10 “(III) by the Indian Health Serv-
11 ice, an Indian tribe or tribal organiza-
12 tion, or an urban Indian organization
13 (as defined in section 4 of the Indian
14 Health Care Improvement Act); or

15 “(IV) under an AIDS Drug As-
16 sistance Program under part B of
17 title XXVI of the Public Health Serv-
18 ice Act.”.

19 (b) EFFECTIVE DATE.—The amendments made by
20 subsection (a) shall apply to costs incurred on or after
21 January 1, 2017.

22 **SEC. 203. PROHIBITION OF USE OF FEDERAL FUNDS FOR**
23 **ABORTION.**

24 No funds authorized or appropriated by this Act (or
25 an amendment made by this Act) may be used to pay for

1 any abortion or to cover any part of the costs of any health
2 plan that includes coverage of abortion, except in the case
3 where a woman suffers from a physical disorder, physical
4 injury, or physical illness that would, as certified by a phy-
5 sician, place the woman in danger of death unless an abor-
6 tion is performed, including a life-endangering physical
7 condition caused by or arising from the pregnancy itself,
8 or unless the pregnancy is the result of an act of rape
9 or incest.

10 **SEC. 204. REAUTHORIZATION OF NATIVE HAWAIIAN**
11 **HEALTH CARE PROGRAMS.**

12 (a) REAUTHORIZATION.—The Native Hawaiian
13 Health Care Act of 1988 (42 U.S.C. 11701 et seq.) is
14 amended by striking “2001” each place it appears in sec-
15 tions 6(h)(1), 7(b), and 10(c) (42 U.S.C. 11705(h)(1),
16 11706(b), 11709(c)) and inserting “2019”.

17 (b) HEALTH AND EDUCATION.—

18 (1) IN GENERAL.—Section 6(c) of the Native
19 Hawaiian Health Care Act of 1988 (42 U.S.C.
20 11705) is amended by adding at the end the fol-
21 lowing:

22 “(4) HEALTH AND EDUCATION.—In order to
23 enable privately funded organizations to continue to
24 supplement public efforts to provide educational pro-
25 grams designed to improve the health, capability,

1 and well-being of Native Hawaiians and to continue
2 to provide health services to Native Hawaiians, not-
3 withstanding any other provision of Federal or State
4 law, it shall be lawful for the private educational or-
5 ganization identified in section 7202(16) of the Ele-
6 mentary and Secondary Education Act of 1965 (20
7 U.S.C. 7512(16)) to continue to offer its educational
8 programs and services to Native Hawaiians (as de-
9 fined in section 7207 of that Act (20 U.S.C. 7517))
10 first and to others only after the need for such pro-
11 grams and services by Native Hawaiians has been
12 met.”.

13 (2) EFFECTIVE DATE.—The amendment made
14 by paragraph (1) takes effect on December 5, 2006.

15 (c) DEFINITION OF HEALTH PROMOTION.—Section
16 12(2) of the Native Hawaiian Health Care Act of 1988
17 (42 U.S.C. 11711(2)) is amended—

18 (1) in subparagraph (F), by striking “and” at
19 the end;

20 (2) in subparagraph (G), by striking the period
21 at the end and inserting “, and”; and

22 (3) by adding at the end the following:

1 “(H) educational programs with the mis-
2 sion of improving the health, capability, and
3 well-being of Native Hawaiians.”.

