

AMENDMENT NO. _____ Calendar No. _____

Purpose: To improve the bill.

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

S. 1790

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

Referred to the Committee on _____ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by _____

Viz:

1 On page 9, line 14, insert “disorders” after “mental
2 health”.

3 On page 23, strike lines 20 through 24 and insert
4 the following:

5 “(2) REQUIREMENT; EXCLUSION.—In estab-
6 lishing a national program under paragraph (1), the
7 Secretary—

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

1 “(B) shall exclude dental health aide thera-
2 pist services from services covered under the
3 program.”.

4 On page 26, between lines 1 and 2, insert the fol-
5 lowing:

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

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

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

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

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

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

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

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

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

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

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

15 “(C) Dental care.

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

22 “(E) Emergency medical services.

23 “(F) Treatment and control of, and reha-
24 bilitative care related to, alcoholism and drug

1 abuse (including fetal alcohol syndrome) among
2 Indians.

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

6 “(H) Home health care.

7 “(I) Community health representatives.

8 “(J) Maintenance and improvement.

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

15 “(c) ALLOCATION; USE.—

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

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

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

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

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

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

24 “(2) AVAILABLE RESOURCES.—The health re-
25 sources available to an Indian tribe or tribal organi-

1 zation include health resources provided by the Serv-
2 ice as well as health resources used by the Indian
3 tribe or tribal organization, including services and fi-
4 nancing systems provided by any Federal programs,
5 private insurance, and programs of State or local
6 governments.

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

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

18 “(f) REPORT.—By no later than the date that is 3
19 years after the date of enactment of the Indian Health
20 Care Improvement Reauthorization and Extension Act of
21 2009, the Secretary shall submit to Congress the current
22 health status and resource deficiency report of the Service
23 for each Service unit, including newly recognized or ac-
24 knowledged Indian tribes. Such report shall set out—

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

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

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

12 “(4) an estimate of—

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

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

23 “(C) the number of Indians using the
24 Service resources made available to each Service
25 unit, Indian tribe or tribal organization, and, to

1 the extent available, information on the waiting
2 lists and number of Indians turned away for
3 services due to lack of resources.

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

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

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

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

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

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

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

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

3 “(2) the amounts appropriated to CHEF under
4 this section.

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

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

18 “(d) REGULATIONS.—The Secretary shall promul-
19 gate regulations consistent with the provisions of this sec-
20 tion to—

21 “(1) establish a definition of disasters and cata-
22 strophic illnesses for which the cost of the treatment
23 provided under contract would qualify for payment
24 from CHEF;

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

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

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

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

18 “(A) Service Units; or

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

21 “(4) establish a procedure for payment from
22 CHEF in cases in which the exigencies of the med-
23 ical circumstances warrant treatment prior to the
24 authorization of such treatment by the Service; and

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(2) DIABETES CONTROL OFFICERS.—

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

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

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

5 Beginning on page 41, strike line 19 and all that fol-
6 lows through page 43, line 7, and insert the following:

7 **SEC. 125. CANCER SCREENINGS.**

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

11 On page 45, between lines 9 and 10, insert the fol-
12 lowing:

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

18 On page 49, strike lines 13 through 18 and insert
19 the following:

20 104–191; 110 Stat. 1936).”.

1 On page 49, between lines 18 and 19, insert the fol-
2 lowing:

3 **SEC. 128. INDIAN YOUTH GRANT PROGRAM.**

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

7 **SEC. 129. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
8 **GRAM.**

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

11 **“SEC. 217. AMERICAN INDIANS INTO PSYCHOLOGY PRO-**
12 **GRAM.**

13 “(a) GRANTS AUTHORIZED.—The Secretary, acting
14 through the Service, shall make grants of not more than
15 \$300,000 to each of 9 colleges and universities for the pur-
16 pose of developing and maintaining Indian psychology ca-
17 reer recruitment programs as a means of encouraging In-
18 dians to enter the behavioral health field. These programs
19 shall be located at various locations throughout the coun-
20 try to maximize their availability to Indian students and
21 new programs shall be established in different locations
22 from time to time.

23 “(b) QUENTIN N. BURDICK PROGRAM GRANT.—The
24 Secretary shall provide a grant authorized under sub-
25 section (a) to develop and maintain a program at the Uni-

1 versity of North Dakota to be known as the ‘Quentin N.
2 Burdick American Indians Into Psychology Program’.
3 Such program shall, to the maximum extent feasible, co-
4 ordinate with the Quentin N. Burdick Indian health pro-
5 grams authorized under section 117(b), the Quentin N.
6 Burdick American Indians Into Nursing Program author-
7 ized under section 115(e), and existing university research
8 and communications networks.

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

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

15 “(1) provides outreach and recruitment for
16 health professions to Indian communities including
17 elementary, secondary, and accredited and accessible
18 community colleges that will be served by the pro-
19 gram;

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

23 “(3) provides summer enrichment programs to
24 expose Indian students to the various fields of psy-

1 chology through research, clinical, and experimental
2 activities;

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

5 “(5) develops affiliation agreements with tribal
6 colleges and universities, the Service, university af-
7 filiated programs, and other appropriate accredited
8 and accessible entities to enhance the education of
9 Indian students;

10 “(6) to the maximum extent feasible, uses exist-
11 ing university tutoring, counseling, and student sup-
12 port services; and

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

15 “(e) ACTIVE DUTY SERVICE REQUIREMENT.—The
16 active duty service obligation prescribed under section
17 338C of the Public Health Service Act (42 U.S.C. 254m)
18 shall be met by each graduate who receives a stipend de-
19 scribed in subsection (d)(4) that is funded under this sec-
20 tion. Such obligation shall be met by service—

21 “(1) in an Indian health program;

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

23 “(3) in the private practice of psychology if, as
24 determined by the Secretary, in accordance with
25 guidelines promulgated by the Secretary, such prac-

1 tice is situated in a physician or other health profes-
2 sional shortage area and addresses the health care
3 needs of a substantial number of Indians.

4 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 \$2,700,000 for fiscal year 2010 and each fiscal year there-
7 after.”.

8 On page 52, between lines 7 and 8, insert the fol-
9 lowing:

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

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

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

22 “(1) provide programs or allowances to transi-
23 tion into an Indian health program, including licens-
24 ing, board or certification examination assistance,

1 and technical assistance in fulfilling service obliga-
2 tions under sections 104, 105, and 115; and

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

10 On page 52, between lines 13 and 14, insert the fol-
11 lowing:

12 **SEC. 130. LIABILITY FOR PAYMENT.**

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

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

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

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

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

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

9 Beginning on page 54, strike line 4 and all that fol-
10 lows through page 55, line 22, and insert the following:

11 **SEC. 131. CONTRACT HEALTH SERVICE ADMINISTRATION**
12 **AND DISBURSEMENT FORMULA.**

13 Title II of the Indian Health Care Improvement Act
14 (25 U.S.C. 1621 et seq.) is amended by adding at the end
15 the following:

16 **“SEC. 226. CONTRACT HEALTH SERVICE ADMINISTRATION**
17 **AND DISBURSEMENT FORMULA.**

18 “(a) SUBMISSION OF REPORT.—As soon as prac-
19 ticable after the date of enactment of the Indian Health
20 Care Improvement Reauthorization and Extension Act of
21 2009, the Comptroller General of the United States shall
22 submit to the Secretary, the Committee on Indian Affairs
23 of the Senate, and the Committee on Natural Resources
24 of the House of Representatives, and make available to

1 each Indian tribe, a report describing the results of the
2 study of the Comptroller General regarding the funding
3 of the contract health service program (including historic
4 funding levels and a recommendation of the funding level
5 needed for the program) and the administration of the
6 contract health service program (including the distribution
7 of funds pursuant to the program), as requested by Con-
8 gress in March 2009, or pursuant to section 830.

9 “(b) CONSULTATION WITH TRIBES.—On receipt of
10 the report under subsection (a), the Secretary shall con-
11 sult with Indian tribes regarding the contract health serv-
12 ice program, including the distribution of funds pursuant
13 to the program—

14 “(1) to determine whether the current distribu-
15 tion formula would require modification if the con-
16 tract health service program were funded at the level
17 recommended by the Comptroller General;

18 “(2) to identify any inequities in the current
19 distribution formula under the current funding level
20 or inequitable results for any Indian tribe under the
21 funding level recommended by the Comptroller Gen-
22 eral;

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

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

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

14 On page 56, between lines 1 and 2, insert the fol-
15 lowing:

16 **SEC. 141. PRIORITY OF CERTAIN PROJECTS PROTECTED.**

17 Section 301 of the Indian Health Care Improvement
18 Act (25 U.S.C. 1631) is amended by adding at the end
19 the following:

20 “(e) **PRIORITY OF CERTAIN PROJECTS PRO-**
21 **TECTED.**—The priority of any project established under
22 the construction priority system in effect on the date of
23 enactment of this Indian Health Care Improvement Reau-
24 thorization and Extension Act of 2009 shall not be af-

1 fected by any change in the construction priority system
2 taking place after that date if the project—

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

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

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

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

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

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

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

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

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

21 Beginning on page 56, strike line 2 and all that fol-
22 lows through page 62, line 5, and insert the following:

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

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

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

7 “(a) PURPOSE AND GENERAL AUTHORITY.—

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

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

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

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

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

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

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

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

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

25 “(2) is authorized—

1 “(A) to waive any leasing prohibition;

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

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

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

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

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

24 “(c) HEALTH CARE DEMONSTRATION PROJECTS.—

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

8 “(A) at an alternative setting; or

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

11 “(2) GENERAL PROJECTS.—

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

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

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

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

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

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

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

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

21 “(i) Cass Lake, Minnesota.

22 “(ii) Mescalero, New Mexico.

23 “(iii) Owyhee and Elko, Nevada.

24 “(iv) Schurz, Nevada.

25 “(v) Ft. Yuma, California.

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

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

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

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

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

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

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

13 “(iii) The project—

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

16 “(II) reduces—

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

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

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

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

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

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

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

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

3 On page 97, between lines 13 and 14, insert the fol-
4 lowing:

5 **SEC. 159. NAVAJO NATION MEDICAID AGENCY FEASIBILITY**
6 **STUDY.**

7 Title IV of the Indian Health Care Improvement Act
8 (25 U.S.C. 1641 et seq.) (as amended by section 158) is
9 amended by adding at the end the following:

10 **“SEC. 411. NAVAJO NATION MEDICAID AGENCY FEASI-**
11 **BILITY STUDY.**

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

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

23 “(1) assigning and paying all expenditures for
24 the provision of services and related administration

1 funds, under title XIX of the Social Security Act, to
2 Indians living within the boundaries of the Navajo
3 Nation that are currently paid to or would otherwise
4 be paid to the State of Arizona, New Mexico, or
5 Utah;

6 “(2) providing assistance to the Navajo Nation
7 in the development and implementation of such enti-
8 ty for the administration, eligibility, payment, and
9 delivery of medical assistance under title XIX of the
10 Social Security Act;

11 “(3) providing an appropriate level of matching
12 funds for Federal medical assistance with respect to
13 amounts such entity expends for medical assistance
14 for services and related administrative costs; and

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

21 “(c) REPORT.—Not later than 3 years after the date
22 of enactment of the Indian Health Care Improvement Re-
23 authorization and Extension Act of 2009, the Secretary
24 shall submit to the Committee on Indian Affairs and Com-
25 mittee on Finance of the Senate and the Committee on

1 Natural Resources and Committee on Energy and Com-
2 merce of the House of Representatives a report that in-
3 cludes—

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

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

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

15 “(4) legislative actions that would be required
16 to authorize the establishment of such entity if such
17 entity is determined by the Secretary to be fea-
18 sible.”.

19 On page 97, between lines 15 and 16, insert the fol-
20 lowing:

21 **SEC. 161. TREATMENT OF CERTAIN DEMONSTRATION**
22 **PROJECTS.**

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

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

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

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

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

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

16 On page 102, line 16, insert “, including by ensuring
17 that all agency directors, managers, and chief executive
18 officers have appropriate and adequate training, experi-
19 ence, skill levels, knowledge, abilities, and education (in-
20 cluding continuing training requirements) to competently
21 fulfill the duties of the positions and the mission of the
22 Service” before the period at the end.

1 On page 106, strike lines 7 through 22 and insert
2 the following:

3 **“SEC. 604. NEVADA AREA OFFICE.**

4 “(a) IN GENERAL.—Not later than 1 year after the
5 date of enactment of this section, in a manner consistent
6 with the tribal consultation policy of the Service, the Sec-
7 retary shall submit to Congress a plan describing the man-
8 ner and schedule by which an area office, separate and
9 distinct from the Phoenix Area Office of the Service, can
10 be established in the State of Nevada.

11 “(b) FAILURE TO SUBMIT PLAN.—

12 “(1) DEFINITION OF OPERATIONS FUNDS.—In
13 this subsection, the term ‘operations funds’ means
14 only the funds used for—

15 “(A) the administration of services, includ-
16 ing functional expenses such as overtime, per-
17 sonnel salaries, and associated benefits; or

18 “(B) related tasks that directly affect the
19 operations described in subparagraph (A).

20 “(2) WITHHOLDING OF FUNDS.—If the Sec-
21 retary fails to submit a plan in accordance with sub-
22 section (a), the Secretary shall withhold the oper-
23 ations funds reserved for the Office of the Director,
24 subject to the condition that the withholding shall

1 not adversely impact the capacity of the Service to
2 deliver health care services.

3 “(3) RESTORATION.—The operations funds
4 withheld pursuant to paragraph (2) may be restored,
5 at the discretion of the Secretary, to the Office of
6 the Director on achievement by that Office of com-
7 pliance with this section.”.

8 On page 111, strike lines 5 through 17.

9 On page 124, line 15, strike “, including Systems of
10 Care, which” and insert “, which may include, if feasible
11 and appropriate, systems of care, and”.

12 On page 127, line 5, strike “subsection” and insert
13 “section”.

14 On page 132, lines 9 and 10, strike “incorporate Sys-
15 tems of Care,” and insert “, if feasible and appropriate,
16 incorporate systems of care”.

17 On page 139, line 5, strike “alcohol and” and insert
18 “alcohol abuse and other”.

1 On page 139, line 11, strike “, including Systems of
2 Care,”.

3 On page 140, line 21, strike “section 701” and insert
4 “section 702”.

5 On page 144, strike lines 17 and 18 and insert the
6 following:

7 **“SEC. 713. CHILD SEXUAL ABUSE PREVENTION AND TREAT-**
8 **MENT PROGRAMS.**

9 On page 145, strike lines 1 and 2, and insert the fol-
10 lowing:

11 “(2) other members of the household or family
12 of the victims described in paragraph (1).

13 Beginning on page 145, strike line 21 and all that
14 follows through page 146, line 5.

15 On page 146, strike lines 19 through 21 and insert
16 the following:

17 “(2) other members of the household or family
18 of the victims described in paragraph (1).

1 On page 147, strike lines 9 through 15 and insert
2 the following:

3 “(3) to purchase rape kits; and

4 “(4) to develop prevention and intervention
5 models, which may incorporate traditional health
6 care practices.

7 On page 156, line 24, strike “mental” and insert “be-
8 havioral”.

9 On page 161, lines 17 and 18, strike “mental” and
10 insert “behavioral”.

11 On page 172, line 20, strike “mental” and insert “be-
12 havioral”.

13 On page 192, line 22, strike “in California” and in-
14 sert “of California”.

15 On page 201, between lines 15 and 16, insert the fol-
16 lowing:

17 **SEC. 196. PRESCRIPTION DRUG MONITORING.**

18 Title VIII of the Indian Health Care Improvement
19 Act (25 U.S.C. 1671 et seq.) (as amended by section 195)
20 is amended by adding at the end the following:

1 **“SEC. 827. PRESCRIPTION DRUG MONITORING.**

2 “(a) MONITORING.—

3 “(1) ESTABLISHMENT.—The Secretary, in co-
4 ordination with the Secretary of the Interior and the
5 Attorney General, shall establish a prescription drug
6 monitoring program, to be carried out at health care
7 facilities of the Service, tribal health care facilities,
8 and urban Indian health care facilities.

9 “(2) REPORT.—Not later than 18 months after
10 the date of enactment of the Indian Health Care Im-
11 provement Reauthorization and Extension Act of
12 2009, the Secretary shall submit to the Committee
13 on Indian Affairs of the Senate and the Committee
14 on Natural Resources of the House of Representa-
15 tives a report that describes—

16 “(A) the needs of the Service, tribal health
17 care facilities, and urban Indian health care fa-
18 cilities with respect to the prescription drug
19 monitoring program under paragraph (1);

20 “(B) the planned development of that pro-
21 gram, including any relevant statutory or ad-
22 ministrative limitations; and

23 “(C) the means by which the program
24 could be carried out in coordination with any
25 State prescription drug monitoring program.

26 “(b) ABUSE.—

1 “(1) IN GENERAL.—The Attorney General, in
2 conjunction with the Secretary and the Secretary of
3 the Interior, shall conduct—

4 “(A) an assessment of the capacity of, and
5 support required by, relevant Federal and tribal
6 agencies—

7 “(i) to carry out data collection and
8 analysis regarding incidents of prescription
9 drug abuse in Indian communities; and

10 “(ii) to exchange among those agen-
11 cies and Indian health programs informa-
12 tion relating to prescription drug abuse in
13 Indian communities, including statutory
14 and administrative requirements and limi-
15 tations relating to that abuse; and

16 “(B) training for Indian health care pro-
17 viders, tribal leaders, law enforcement officers,
18 and school officials regarding awareness and
19 prevention of prescription drug abuse and strat-
20 egies for improving agency responses to ad-
21 dressing prescription drug abuse in Indian com-
22 munities.

23 “(2) REPORT.—Not later than 18 months after
24 the date of enactment of the Indian Health Care Im-
25 provement Reauthorization and Extension Act of

1 2009, the Attorney General shall submit to the Com-
2 mittee on Indian Affairs of the Senate and the Com-
3 mittee on Natural Resources of the House of Rep-
4 resentatives a report that describes—

5 “(A) the capacity of Federal and tribal
6 agencies to carry out data collection and anal-
7 ysis and information exchanges as described in
8 paragraph (1)(A);

9 “(B) the training conducted pursuant to
10 paragraph (1)(B);

11 “(C) infrastructure enhancements required
12 to carry out the activities described in para-
13 graph (1), if any; and

14 “(D) any statutory or administrative bar-
15 riers to carrying out those activities.”.

16 **SEC. 197. TRIBAL HEALTH PROGRAM OPTION FOR COST**
17 **SHARING.**

18 Title VIII of the Indian Health Care Improvement
19 Act (25 U.S.C. 1671 et seq.) (as amended by section 196)
20 is amended by adding at the end the following:

21 **“SEC. 828. TRIBAL HEALTH PROGRAM OPTION FOR COST**
22 **SHARING.**

23 “(a) IN GENERAL.—Nothing in this Act limits the
24 ability of a tribal health program operating any health
25 program, service, function, activity, or facility funded, in

1 whole or part, by the Service through, or provided for in,
2 a compact with the Service pursuant to title V of the In-
3 dian Self-Determination and Education Assistance Act
4 (25 U.S.C. 458aaa et seq.) to charge an Indian for serv-
5 ices provided by the tribal health program.

6 “(b) SERVICE.—Nothing in this Act authorizes the
7 Service—

8 “(1) to charge an Indian for services; or

9 “(2) to require any tribal health program to
10 charge an Indian for services.”.

11 **SEC. 198. DISEASE AND INJURY PREVENTION REPORT.**

12 Title VIII of the Indian Health Care Improvement
13 Act (25 U.S.C. 1671 et seq.) (as amended by section 197)
14 is amended by adding at the end the following:

15 **“SEC. 829. DISEASE AND INJURY PREVENTION REPORT.**

16 “Not later than 18 months after the date of enact-
17 ment of the Indian Health Care Improvement Reauthor-
18 ization and Extension Act of 2009, the Secretary shall
19 submit to the Committee on Indian Affairs of the Senate
20 and the Committees on Natural Resources and Energy
21 and Commerce of the House of Representatives describ-
22 ing—

23 “(1) all disease and injury prevention activities
24 conducted by the Service, independently or in con-

1 junction with other Federal departments and agen-
2 cies and Indian tribes; and

3 “(2) the effectiveness of those activities, includ-
4 ing the reductions of injury or disease conditions
5 achieved by the activities.”.

6 **SEC. 199. OTHER GAO REPORTS.**

7 Title VIII of the Indian Health Care Improvement
8 Act (25 U.S.C. 1671 et seq.) (as amended by section 198)
9 is amended by adding at the end the following:

10 **“SEC. 830. OTHER GAO REPORTS.**

11 “(a) COORDINATION OF SERVICES.—

12 “(1) STUDY AND EVALUATION.—The Comp-
13 troller General of the United States shall conduct a
14 study, and evaluate the effectiveness, of coordination
15 of health care services provided to Indians—

16 “(A) through Medicare, Medicaid, or
17 SCHIP;

18 “(B) by the Service; or

19 “(C) using funds provided by—

20 “(i) State or local governments; or

21 “(ii) Indian tribes.

22 “(2) REPORT.—Not later than 18 months after
23 the date of enactment of the Indian Health Care Im-
24 provement Reauthorization and Extension Act of

1 2009, the Comptroller General shall submit to Con-
2 gress 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 Health Care Im-
20 provement Reauthorization and Extension Act of
21 2009, the Comptroller General shall submit to Con-
22 gress a report on the study conducted under para-
23 graph (1), together with recommendations regard-
24 ing—

1 “(A) the appropriate level of Federal fund-
2 ing that should be established for health care
3 under the contract health services program de-
4 scribed in paragraph (1);

5 “(B) how to most efficiently use that fund-
6 ing; and

7 “(C) the identification of any inequities in
8 the current distribution formula or inequitable
9 results for any Indian tribe under the funding
10 level, and any recommendations for addressing
11 any inequities or inequitable results identified.

12 “(4) CONSULTATION.—In conducting the study
13 under paragraph (1) and preparing the report under
14 paragraph (3), the Comptroller General shall consult
15 with the Service, Indian tribes, and tribal organiza-
16 tions.”.

17 **SEC. 200. TRADITIONAL HEALTH CARE PRACTICES.**

18 Title VIII of the Indian Health Care Improvement
19 Act (25 U.S.C. 1671 et seq.) (as amended by section 199)
20 is amended by adding at the end the following:

21 **“SEC. 831. TRADITIONAL HEALTH CARE PRACTICES.**

22 “Although the Secretary may promote traditional
23 health care practices, consistent with the Service stand-
24 ards for the provision of health care, health promotion,
25 and disease prevention under this Act, the United States

1 is not liable for any provision of traditional health care
2 practices pursuant to this Act that results in damage, in-
3 jury, or death to a patient. Nothing in this subsection shall
4 be construed to alter any liability or other obligation that
5 the United States may otherwise have under the Indian
6 Self-Determination and Education Assistance Act (25
7 U.S.C. 450 et seq.) or this Act.”.

8 Beginning on page 201, strike line 18 and all that
9 follows through page 207, line 3.

10 Beginning on page 207, strike line 19 and all that
11 follows through page 214, line 21.