intermediary to improve the accessibility of health services to California Indians.

(b) Agreement with California Rural Indian Health Board

(1) In establishing such program, the Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred, during the period of the demonstration program, in providing medical treatment under contract to California Indians described in section 1679(b)[1] of this title throughout the California contract health services delivery area described in section 1680 of this title with respect to high-cost contract care cases.

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

(3) No payment may be made for treatment provided under the demonstration program to the extent payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 1621a of this title or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

(c) Advisory board

There is hereby established an advisory board which shall advise the California Rural Indian Health Board in carrying out the demonstration pursuant to this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under such demonstration, at least one half of whom are not affiliated with the California Rural Indian Health Board.

(d) Commencement and termination dates

The demonstration program described in this section shall begin on January 1, 1993, and shall terminate on September 30, 1997.

(e) Report

Not later than July 1, 1998, the California Rural Indian Health Board shall submit to the Secretary a report on the demonstration program carried out under this section, including a statement of its findings regarding the impact of using a contract care intermediary on—

(1) access to needed health services;

(2) waiting periods for receiving such services; and

(3) the efficient management of high-cost contract care cases.

(f) "High-cost contract care cases" defined

For the purposes of this section, the term ''high-cost contract care cases'' means those cases in which the cost of the medical treatment provided to an individual—

(1) would otherwise be eligible for reimbursement from the Catastrophic Health Emergency Fund established under section 1621a of this title, except that the cost of such treatment does not meet the threshold cost requirement established pursuant to section 1621a(b)(2)[1] of this title; and

(2) exceeds $1,000.

(Pub. L. 94–437, title II, § 211, as added Pub. L. 102–573, title II, § 206(c), Oct. 29, 1992, 106 Stat. 4549; amended Pub. L. 104–313, § 2(c), Oct. 19, 1996, 110 Stat. 3822; Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

References in Text

Section 1679 of this title, referred to in subsec. (b)(1), was repealed and a new section 1679 was enacted by Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935. Provisions describing California Indians, similar to those that appeared in former section 1679(b) are now contained in new section 1679(a).

Section 1621a of this title, referred to in subsec. (f)(1), was amended generally by Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935, and, as so amended, no longer contains a subsec. (b)(2).

Codification

Amendment by Pub. L. 111–148 is based on section 101(b)(3) of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

Amendments

2010—Subsec. (g). Pub. L. 111–148 struck out subsec. (g) which authorized appropriations for fiscal years 1996 through 2000.

1996—Subsec. (g). Pub. L. 104–313 substituted ''1996 through 2000'' for ''1993, 1994, 1995, 1996, and 1997''.

Termination of Advisory Boards

Advisory boards established after Jan. 5, 1973, to terminate not later than the expiration of the 2-year period beginning on the date of their establishment, unless, in the case of a board established by the President or an officer of the Federal Government, such board is renewed by appropriate action prior to the expiration of such 2-year period, or in the case of a board established by Congress, its duration is otherwise provided by law. See sections 3(2) and 14 of Pub. L. 92–463, Oct. 6, 1972, 86 Stat. 770, 776, set out in the Appendix to Title 5, Government Organization and Employees.

§ 1621k. Coverage of screening mammography

The Secretary, through the Service, shall provide for screening mammography (as defined in section 1861(jj) of the Social Security Act [42 U.S.C. 1395x(jj)]) for Indian and urban Indian women 35 years of age or older at a frequency, determined by the Secretary (in consultation with the Director of the National Cancer Institute), appropriate to such women, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act [42 U.S.C. 1395j et seq.] and other cancer screenings.

(Pub. L. 94–437, title II, § 212, as added Pub. L. 102–573, title II, § 207(a), Oct. 29, 1992, 106 Stat. 4550; amended Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

References in Text

The Social Security Act, referred to in text, is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Part B of title XVIII of the Act is classified generally to part B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of

[1] See References in Text note below.

Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

CODIFICATION

Amendment by Pub. L. 111–148 is based on section 128 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

AMENDMENTS

2010—Pub. L. 111–148 inserted "and other cancer screenings" before period at end.

§ 1621*l*. Patient travel costs

(a) Definition of qualified escort

In this section, the term "qualified escort" means—

(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

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

(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

(b) Provision of funds

The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this chapter—

(1) emergency air transportation and nonemergency air transportation where ground transportation is infeasible;

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

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

(Pub. L. 94–437, title II, § 213, as added Pub. L. 102–573, title II, § 208, Oct. 29, 1992, 106 Stat. 4551; amended Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

REFERENCES IN TEXT

The Indian Self-Determination and Education Assistance Act, referred to in subsec. (b), is Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2203, which is classified principally to subchapter II (§ 450 et seq.) of chapter 14 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 450 of this title and Tables.

This chapter, referred to in subsec. (b), was in the original "this Act", meaning Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400, known as the Indian Health Care Improvement Act, which is classified principally to this chapter. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of this title and Tables.

CODIFICATION

Amendment by Pub. L. 111–148 is based on sections 101(c)(2) and 129 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which were enacted into law by section 10221(a) of Pub. L. 111–148.

AMENDMENTS

2010—Pub. L. 111–148 amended section generally. Prior to amendment, section directed Secretary to provide funds for patient travel costs for emergency air transportation and nonemergency air transportation where ground transportation was infeasible and authorized appropriations for fiscal years 1993 to 2000.

Pub. L. 111–148 substituted "The Secretary" for "(a) The Secretary" prior to general amendment of section. See above.

§ 1621m. Epidemiology centers

(a) Establishment of centers

(1) In general

The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in subsection (b).

(2) New centers

(A) In general

Subject to subparagraph (B), any new center established after March 23, 2010, may be operated under a grant authorized by subsection (d).

(B) Requirement

Funding provided in a grant described in subparagraph (A) shall not be divisible.

(3) Funds not divisible

An epidemiology center established under this subsection shall be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), but the funds for the center shall not be divisible.

(b) Functions of centers

In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

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

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

(3) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

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

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

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

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